

Medical Economics

FEBRUARY 1957

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Fees in
Three
Areas



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1. Derome, L.: Canad. M. A. J. 69:532, 1983.

2. Hardin, J. H., et al.: South. M. J. 47:1190, 1994.

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Medical Economics

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, FEB., 1957

SPECIAL FEATURES

***Malpractice Mishaps: the Missing Evidence* 112**

This M.D. did nothing wrong; he merely neglected to do something right. Result: a suit that kept him on tenterhooks for a whole year

***Yardsticks for Your Practice* 115**

The sixth in a series of reports based on MEDICAL ECONOMICS' 8th Quadrennial Survey, to which 10,919 physicians contributed data

***Doctors' Working Hours* 116**

For every eight hours the typical American works, the typical private physician devotes twelve hours to the actual practice of medicine

***How Your Patient Load Compares* 122**

If you're typical, you see about 15 per cent fewer patients than you saw during 1952. And you spend more minutes with each one

***Are Your Hospital Rights Well Protected?* 130**

It takes more than an M.D. on the governing board to guard your privileges; it takes a joint conference committee, says this author

MORE ►

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Now, for the first time, you can compare your fees for a whole spectrum of procedures with those of colleagues in other locales

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A patient doesn't always put these questions directly to you—but they're likely to be on his mind. Here's how to handle them

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I. Tittle, C.R.: *The Effects of 3,5,3'-L-Triiodothyronine in Patients with Metabolic Insufficiency*, *J.A.M.A.* 162:271 (Sept. 22) 1956.

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Are you interested in a Low-Fat Breakfast?

In the dietary regimens recommended by nutrition and medical authorities for the purpose of *reducing fat in the diet* the importance of the morning meal is given full recognition. That a low-fat breakfast should be adequate not only in calories, but also in its content of essential nutrients, is advocated by medical as well as nutrition authorities.

BASIC CEREAL LOW-FAT AND LOW-CHOLESTEROL BREAKFAST PATTERN

Orange juice, fresh, $\frac{1}{2}$ cup,
Cereal, 1 oz., with whole
milk, $\frac{1}{2}$ cup, and sugar,
1 tsp., Bread, white, 2
slices, with butter, 1 tsp.,
Milk, nonfat (skim), 1 cup,
black coffee.

The basic cereal breakfast pattern shown below is *low in fat and low in cholesterol* and makes a worth-while contribution of complete protein, essential B vitamins, and minerals. Thus it merits inclusion in dietary regimens for the purpose of reducing fat in the diet.

Nutritive Value of Basic Cereal Breakfast Pattern

Calories.....	502
Protein.....	20.5 gm.
Fat.....	11.6 gm.
Carbohydrate.....	80.7 gm.
Calcium.....	0.532 gm.
Iron.....	2.7 mg.
Vitamin A.....	600 I. U.
Thiamine.....	0.46 mg.
Riboflavin.....	0.80 mg.
Niacin.....	3.0 mg.
Ascorbic Acid.....	65.5 mg.
Cholesterol.....	32.9 mg.

Note: To further reduce fat and cholesterol use skim milk on cereal which reduces Fat Total to 7.0 gm. and Cholesterol Total to 16.8 mg. Preserves or honey as spread further reduces Fat and Cholesterol.

Bower, A. deP., and Church, C. F.: *Food Values of Portions Commonly Used*. 8th ed. Philadelphia: A. deP. Bower, 1956.
Cereal Institute, Inc.: *The Nutritive Contribution of Breakfast Cereals*. Chicago: Cereal Institute, Inc., 1956.
Hayes, O. B., and Rose, G. K.: *A Supplementary Food Composition Table for Dietary Studies*. J. Am. Dietet. A.: Jan. 1957

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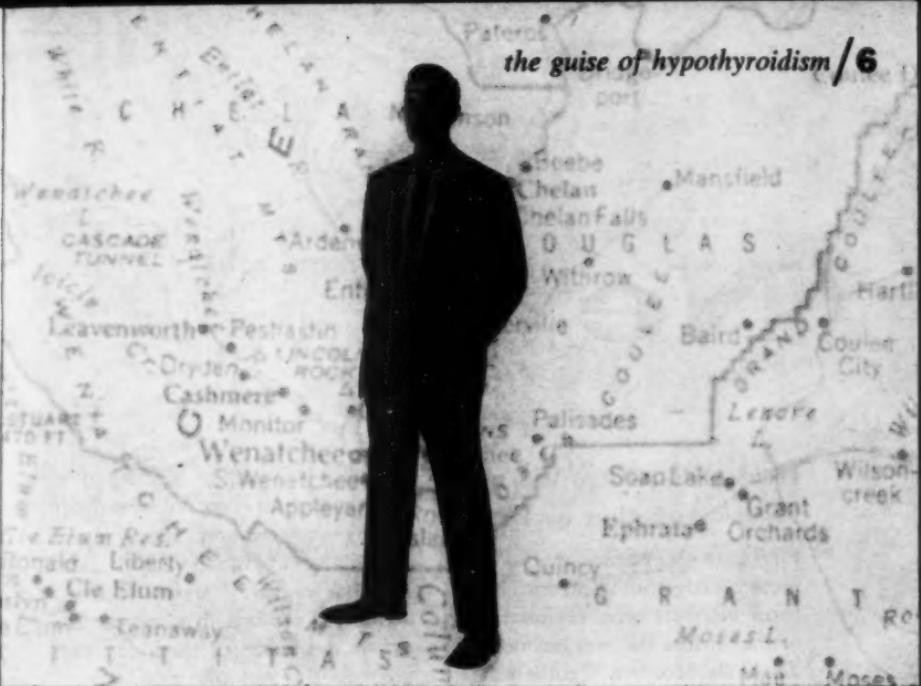
SIGNIFICANT: Wilkins, R. W.: Mississippi Doctor 30:359, 1953. Wilkins, R. W., and Judson, W. E.: New England Jrl. of Medicine 248:48, 1953. Duncan, Garfield G.: Philadelphia Medicine 51:24, 1956.

sample and literature on request

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a "diagnostic map" that's hard to read

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*Pickering, D. E., and Lusted, L. B.: GP 11:99 (Feb.) 1955.

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News

Health Plans Are Warned: 'Work Together or Else'

Physician-sponsored prepay plans must get together in offering a uniform contract on a regional basis or they'll lose the best business. So warns Dr. Morris K. Crothers, head of Oregon Blue Shield.

His warning is aimed in particular at the Western plans. Several of them, he points out, "now cover a smaller percentage of the population than they did five or ten years ago." Meanwhile, the commercial insurance companies "have been rapidly increasing their enrollments."

Why are physician-sponsored plans losing out? Because they're "cut up into small geographic units," Dr. Crothers says. "More and more of the better class of [in-



Crothers

surance] business . . . is going to be sold through large corporate units or through large union groups representing areas much larger than counties or single states. It is essential, if we are to compete for the best blocks of business, that we meet this situation . . .

"We have often hidden behind the statements that prepayment originated in the Pacific Northwest . . . [Actually,] we stand in some danger of having the pioneer element of health insurance taken out of our hands. . . A Uniform Western Conference Contract is ready for submission to . . . all plans. I urge that . . . each Board of Trustees be asked to approve the uniform contract."

Malpractice Rx Reduced To Just 61 Words

Possibly the most pointed malpractice warning on record has been circulated among medical society members in Westchester County, N.Y. It comes to exactly sixty-one

words, eighteen of them epithets. Here it is verbatim:

"You may think your patient or your colleague is an ape, an ass, a blockhead, a booby, a bumpkin, a chump, a crank, a dolt, a donkey, a dummy, a dunce, a fool, an idiot, an ignoramus, an imbecile, a moron, a nincompoop, a sap-head, or something worse. But don't say it; just give good medical care and keep good records!"

Tough Dilemma Seen In Insurance Work

Doctors who examine prospective policyholders for life insurance companies face an economic dilemma that's almost impossible to resolve. They have to choose between (1) doing a good job and losing money, and (2) doing a fast, superficial job and making money.

So says Dr. Preston J. Burnham of Salt Lake City, who delineates this hard choice:

On the one hand, the examining doctor has an obligation to the pa-

tient. Fulfilling it might require him to "spend a total of two or more hours" investigating a possibly disabling handicap. After all, says Dr. Burnham, the patient is really the one who pays for the examination.

On the other hand, the examining doctor has a duty to the insurance agent and to the company. To satisfy the agent, "a physician may spend ten minutes on the examination [and] pass everyone the agent sends him . . ." Or, to satisfy the company, a physician may "disqualify many clients . . . in the first few minutes for fear of passing someone whose apparently shortened statistical life expectancy . . . might help bankrupt the company."

Either way, the emphasis is on speed. So Dr. Burnham concludes:



Burnham

Snapshots

PHYSICIANS' EARNINGS are still climbing—but not so fast as the earnings of corporate executives and factory workers. Pay boosts for each of these two groups averaged 5.9 per cent last year. Medical incomes have been rising at a 5.5 per cent annual rate.

DOES YOUR WIFE do volunteer work for a hospital, a church, or some similar charity? If so, you can now deduct some of her out-of-pocket expenses on your joint tax return. List her travel costs and her uniform costs as charitable contributions.

FAMILY DOCTOR'S WINDFALL: A woman in Palm Beach, Fla., died recently and left a surprise legacy to her family physician. The legacy: \$300,000 tax-free. The physician: Walter G. Robinson, 42.

ARGUMENT STARTERS: When Pageant Magazine cast about for "seven sure-fire controversial subjects" guaranteed to generate heat in any conversational group, it found four of the seven in the medical field. The quarrel-worthy quartet: birth control, euthanasia, fluoridation, vivisection.

"The physician [interested] in insurance examining would do well to consider whether he wishes to do a \$7.50 exam every ten minutes . . . and have a large insurance practice, or whether he will maintain his obligation to the patient and risk an early termination to his insurance examining career."

Co-ops Claim Gains Over Organized Medicine

The Cooperative League of the U.S.A. is claiming "the fifth successive co-op victory over organized medical boycotts." Five times, it says, a consumer-sponsored health plan has sued a local medical society for refusing membership to its doctors. And "no co-op has ever lost such a suit."

The first four suits took place in Washington, D.C.; Elk City, Okla.; Seattle, Wash.; and San Diego, Calif. They're now history—some of them ancient history. But the fifth suit is news.

Here's the story:

Some time ago, the health co-op in Two Harbors, Minn., sued the St. Louis County (Minn.) Medical Society for excluding its four doctors from medical society membership. This amounted to "an anti-trust conspiracy to limit the co-op's services and increase its costs," it was charged.

The suit never came to trial. Just recently the issue was resolved

when the medical society accepted the co-op's doctors as members. That's the victory the co-ops are claiming.

And they're claiming it as a victory over the A.M.A. Says the Co-operative League: "The idea of paying a physician a salary is anathema to A.M.A. leaders. [It] upsets the whole system of fee-for-service-when-you're-sick that medical economics is now based on."

British Doctors Blast State Health Service

"We have had amply demonstrated to us that medicine and politics do not mix, something the profession has always instinctively known but has been rather reluctant to admit without trial. Maybe the trial was necessary to bring home [this] painful truth . . ."

Thus does a recent editorial in the British Medical Journal sum up the doctors' discontent after nearly nine years' experience with the National Health Service. So widespread is their disillusionment that their continued cooperation with the N.H.S. appears to be in real doubt.

What has brought the profession to the boiling point? A promise made—and repeatedly broken—by the British Government. Here's the story:

When the N.H.S. went into effect, British doctors understood

Snapshots

BUYING LIFE INSURANCE via the "bank-loan plan" may soon be stopped. Right now you can buy a limited-payment policy, then borrow from a bank to pay the premiums. Your only expense is interest on the bank loan—and that's tax-deductible. This last feature is a "tax loophole" Congress may close.

HEADACHE SCALE stems from a study by Dr. Henry D. Ogden of New Orleans. Of all the occupational groups he interviewed, medical students reported the most headaches. Farmers reported the fewest.

PSYCHOLOGISTS TRIED to get a licensure law in New York State. Psychiatrists objected, fearing this might further confuse the two fields. So the two groups compromised on a certification law. It requires persons calling themselves psychologists to have their educational background certified by the state.

HANDS-FREE TELEPHONE now on the market lets you talk on the phone while examining a patient or looking at X-rays. It has a built-in loudspeaker and a microphone that can pick up your voice from twenty feet away.

that the Government had accepted the recommendations of the so-called Spens Committees. These called for regular cost-of-living adjustments in the sums paid to doctors under the N.H.S. But successive Ministers of Health have disregarded these recommendations. And so has the present Minister—on grounds that the recommendations applied only to the first year the N.H.S. was in operation.

Says the British Medical Journal: "The profession will have only one interpretation of the present Government's attitude and action—that it has broken faith . . . It is now crystal clear that the Government's original acceptance of these [recommendations] was insincere . . . Until now the profession has for nearly nine years been reluctant to believe that was the case."

The present crisis goes far deeper than "a mere question of payment for work done in accordance with Governmental promise," the Journal adds. "It is a crisis of confidence between Medicine and the State. It brings to the fore the question of the soundness of the National Health Service in its present form . . . This . . . demands investigation by the profession from the base upwards."

Whatever British doctors decide to do, the Journal says, "the sick and the suffering will be cared for as they always have been." But not necessarily through the N.H.S. Not

if doctors remain "infuriated by the cavalier treatment meted out to them . . . disgusted by this present flagrant breach of faith."

Survey Pinpoints Needs Of Medical Students

How many medical students need financial help? In a survey of the student bodies of thirty medical schools, the Student American Medical Association has found about 5 per cent in "real and immediate need" of such support.

How much help do they need? From several hundred dollars to more than \$3,000 apiece, with a majority needing at least \$1,000. In many cases the sum represents debts already incurred.

Total additional help needed in the schools surveyed, according to the S.A.M.A.: more than \$1,500,000 annually.

Which Mutual Funds Grow Fastest?

Suppose that back in 1946 you had invested \$10,000 in an open-end mutual fund that aimed for capital growth. How much would your capital actually have grown during the next ten years?

If you'd picked one of the best funds, your \$10,000 would have ballooned into almost \$40,000. In some other growth funds, though, you'd have fared only half that well.

Those are the conclusions relayed to doctors by Professional Management of Waterloo, Iowa. The firm first studied the performance records of all growth funds as published in "Investment Companies," the standard reference work

by Arthur Wiesenberger. As Professional Management sums it up for doctors: "Wise selection of an investment fund can very easily make a difference of \$100 to \$200 per month in retirement income."

The table below shows how

How Fast Have the Growth Funds Grown?

SIX FASTEST-GROWING FUNDS

	Value of Your Investment		Average Annual Gain
	1/1/46	12/31/55	
Chemical Fund	\$10,000	\$39,772	30%
Eaton & Howard Stock Fund	10,000	38,317	28
Growth Industry Shares	10,000	37,954	28
Fidelity Fund	10,000	37,418	27
Keystone—S-3	10,000	36,725	27
Founders Mutual Fund	10,000	36,524	26

SIX SLOWEST-GROWING FUNDS

National Investors	\$10,000	\$29,995	20%
Financial Fund	10,000	29,447	19
Selected Shares	10,000	27,217	17
National Growth Fund	10,000	26,177	16
Group Stock Fund	10,000	25,370	15
Aberdeen Fund	10,000	21,058	11

NEWS

you'd have made out in twelve different growth funds, assuming you'd invested \$10,000 ten years ago and reinvested all dividends and capital gains received. Remember that the period studied was one of generally rising security prices. Remember, too, that past performance is no guarantee of future results.

Physicians Forum Tries A New Approach

Compulsory national health insurance "could not receive serious attention in this session of Congress." On the basis of this conclusion, the Physicians Forum has been casting

about for a substitute program. It now reports "serious areas of disagreement" among its members as to which way to turn.

According to the Forum's program-drafting committee: "Some contended that the Forum should support only National Health Insurance or a direct step in this direction." These people felt it wrong to recognize voluntary health plans. They felt the latter "create vested interests, thus complicating the ultimate task and postponing its [completion]."

Another group argued that the voluntary plans were now well-established and that "by building on them, a universal national program

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Vitamin C	60 mg. (Ascorbic Acid)
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WHEN CONSTIPATION WAS A PROBLEM to the Egyptians—

Imhotep, the "first physician," discovered castor oil (2850 B.C.), which was later described in the Ebers Papyrus. Purging was not outmoded until the present century.

WHEN ATONIC CONSTIPATION IS A PROBLEM .. to

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BEFORE PARENZYME



AFTER PARENZYME

Diabetic Ulceration

Female diabetic, 72 years old. Peripheral arteritis obliterans, with cellulitis and gangrenous ulcerations. Burning pain.



Parenzyme i.m., 0.5 ml. q. 8 h., at end of 24 hours the palpebral fissure was wider, corneal clearing was apparent and pain much less severe. After 36 hours, frequency of injections reduced to q. 12 h. basis. Discharged as cured at end of 2 weeks.

Time between photos 9 weeks. Parenzyme administered daily. Healing of ulcer complete. Pain and edema eliminated.

Parenzyme®

INTRAMUSCULAR TRYPSIN

anti-inflammatory effects without steroid reactions

Fibrin deposits in the minute pores of the capillaries, lymphatics and intercellular tissue spaces form a major barrier to the speedy resolution of inflammation.¹ Martin¹ believes that Parenzyme (intramuscular trypsin) after injection is selectively adsorbed by fibrin and acts as a depolymerase at the inflammatory site. By this action fibrin deposits are removed, tissue permeability is restored and inflammatory exudates are resorbed. Local circulation is re-established permitting tissue repair to proceed.²

Indications: Inflammatory disorders characterized by edema such as traumatic wounds, bruises, contusions, phlebitis, thrombophlebitis, phlebothrombosis, decubitus, diabetic and varicose ulcers, iritis, iridocyclitis and chorioretinitis.

Note: Where infection is present or suspected concurrent administration of antibacterial agents is recommended.

Dosage: 5 mg. (1 ml.) once or twice daily. For severe acute conditions two injections

daily are recommended for the first one or two days until inflammation begins to subside, then once daily or less frequently as indicated. Use dry syringe, inject very slowly intragluteally.

Supplied: 5 ml. multiple dose vials (5 mg. purified crystalline trypsin/ml.)

References: 1. Martin, G. J.: Lecture before Delaware Academy of General Practice, Wilmington, Delaware, Dec. 11, 1954. 2. Wildman, C. J.: Angiology 6:473, 1955.

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Parenzyme *Aqueous* provides the proven therapeutic efficacy of Parenzyme—in a new aqueous menstruum. With Parenzyme *Aqueous*, oil sensitivity reactions are eliminated. Pain is significantly reduced. Of all intramuscular proteolytic enzymes, only Parenzyme *Aqueous* can provide these advantages:

- *Less pain on injection*
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Dosage: Equivalent to Parenzyme in oil.

Supplied: Sterile multiple dose vials containing lyophilized trypsin, 25 mg., plus 5 ml. vial of aqueous diluent.

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NEWS

will evolve as it has in many European countries."

These differences of opinion "were never fully resolved", the committee comments. Even so, it's come up with a compromise proposal featuring Federal grants-in-aid to the states for these three purposes:

• "Subsidizing premiums for approved medical care insurance. Each person (or his employer or union on his behalf) would contribute a fixed percentage of income (such as 3 per cent). The difference between this contribution and the premium would be met by the proposed Federal grant.

• "Helping to establish approved medical care insurance . . . in areas where this is not available.

• "Constructing and equipping facilities for group practice medical care insurance plans."

Another part of the committee's proposal: the addition of medical care benefits to those now being received by Social Security beneficiaries. This, says the committee, is "essentially the recommendation unanimously adopted by the 1952 President's Commission on the Health Needs of the Nation . . . The provision of hospital or physician's services to [Social Security] beneficiaries would seem likely to attract considerable public support . . ."

In case anyone misses the obvious point, the committee adds: "This proposal is the start of a system of compulsory national health insurance." [MORE NEWS ON 328]



AGE . . . In older people, chronic constipation and biliary dyspepsia are often the result of decreased food and water intake, inactivity, intestinal muscle atonicity, increased anorectal disorders, biliary stasis.

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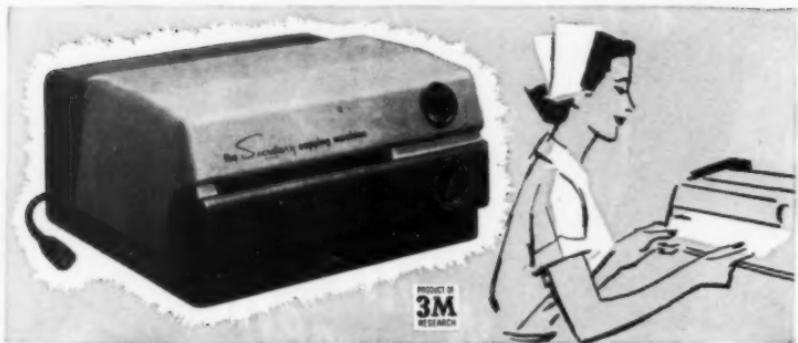
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1. Maynert, E. W. and Losin, L.: *J. Pharmacol. & Exper. Therap.* **115**:275-282 (Nov.) 1955.
2. Butler, T. C. et al.: *J. Pharmacol. & Exper. Therap.* **111**:425 (Aug.) 1954.

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1. Stieglitz, E. J.: In *Modern Nutrition in Health and Disease*, ed. by Wohl, M. G. and Goodhart, R. S., Lea and Febiger, Philadelphia, 1955, p. 945.



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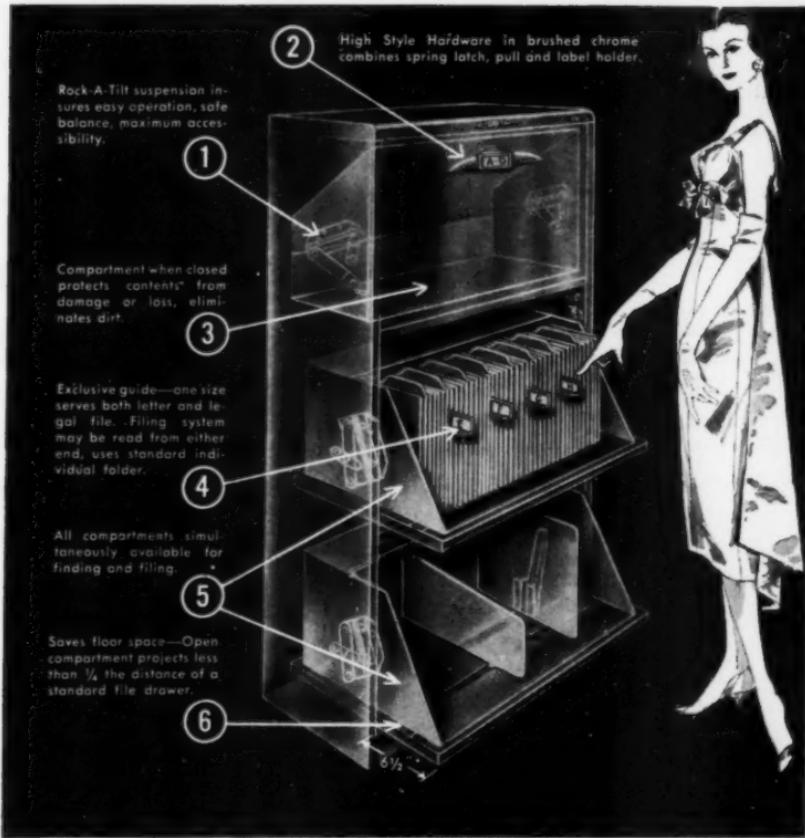
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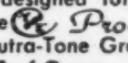


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adds cold relief to cough control

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the cough... Both throat "tickle" and cough are relieved by CORICIDIN Syrup through its suppressive, decongestant and expectorant action.

the cold... Sneezing, nasal discharge and other allergy-like symptoms of a cold are soon cleared by the unexcelled antihistamine in CORICIDIN Syrup.

and the patient... By stemming the progress of a cold, CORICIDIN Syrup helps prevent the often stormy aftermath of unchecked colds. Patients feel better, sleep better and recover more rapidly.

Each teaspoonful (5 cc.) of CORICIDIN Syrup® contains:	
Dihydrocodeineone bitartrate	1.67 mg.
Chlorprophénopyridamine maleate	2 mg.
Sodium salicylate	225 mg.
Sodium citrate	120 mg.
Caffeine	30 mg.
Glyceryl guaiacolate	30 mg.

CORICIDIN Syrup is compatible with therapeutic amounts of other medicaments, such as codeine salts, belladonna tincture and ephedrine sulfate.

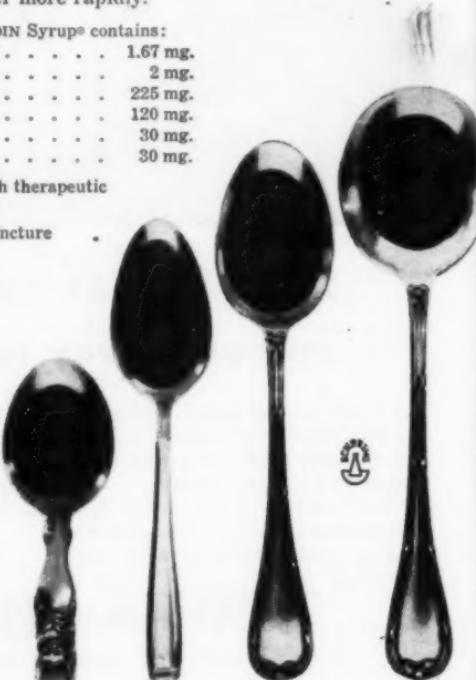
dosage - Adults - One teaspoonful every three or four hours, not exceeding four doses daily.

Children 6-12 years - One-half adult dosage.

Younger children - Adjust dosage according to age.

packaging - CORICIDIN® Syrup, 4-ounce, pint and gallon bottles.

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Typical examples of what the NEW anti-inflammatory enzyme can do

Woman. Sty fistulized through conjunctiva. Edema tremendous. Patient in great pain. Injection of 0.5 cc. of Chymar three times a day.

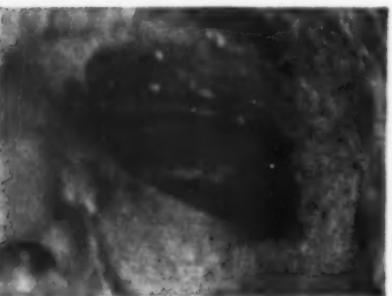


←
24 hours after in-
jection of Chymar.
Edema reduced.
Eye slightly less
painful.



→
8th day. Only
small amount of
redness in con-
junctiva. Lids
normal. No
swelling.

72 year old man fell and struck eye on door knob. Typical "black eye." Chymar injected in 0.5 cc. doses every 8 hours.



←
Picture 4 hours
after incident.
Patient in con-
siderable pain.



→
3rd day after
starting Chymar.
Note marked
reduction in
swelling.

Traumatic face injury. Lineal maxillary fracture. Upper jaw hanging loosely. Surgery. Through and through pin. Teeth wired, anchored to head cast. Tracheotomy because of excessive edema. 0.5 cc. of Chymar injected three times daily.



←
Patient immedi-
ately after surgery.



→
4th day after
surgery. Trache-
otomy tube
removed. Patient
comfortable. No
edema. Chymar
stopped.

CHYMAR

injectable anti-inflammatory enzymatic agent with systemic action

what it is—

Chymar is a suspension of chymotrypsin, a proteolytic enzyme, in sesame oil, for *intramuscular injection*.

what it does—

Chymar controls inflammation and restores normal circulation. It hastens absorption of hematomas, minimizes tissue necrosis and promotes healing.

what it's for—

Chymar is indicated in: chronic ulcers (stasis, varicose, diabetic); reduction of hematomas; swelling due to trauma; cellulitis; bursitis and arthritis; phlebitis; and inflammation of the eye (iritis, iridocyclitis, chorioretinitis, uveitis).

why Chymar is so safe—

There are no systemic side effects with Chymar. Chymar does not interfere with blood clotting, and no clotting time or serum protein determinations are necessary. There are no known contraindications to Chymar, and no known incompatibilities.

Chymar is supplied in 5 cc. vials.

Chymar must not be given intravenously.



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memory lapses



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for middle-age slowdown

Plestran is indicated as an aid in restoration of vigor in middle-aged or elderly patients who complain of chronic fatigue... reduced vitality... low physical reserve... impaired work capacity... depression... muscular aches and pains... or cold intolerance. Such "signs of aging," far from being due to physiologic disturbances, may often result from endocrine imbalance, especially gonadal and thyroid dysfunction.¹⁻⁴ Plestran provides ethinyl estradiol (0.005 mg.); methyltestosterone (2.5 mg.), and Proloid[®] (1/4 gr.)—hormones which help to correct endocrine imbalance and often halt or reverse involutional and degenerative changes.¹⁻⁴

Plestran restores work capacity and a sense of well-being, usually within 7 to 10 days. It improves nitrogen balance, leads to better muscle tone and vigor, enhances mental alertness, helps to cor-

*Purified thyroid globulin

rect osteoporosis, senile skin and hair texture changes and relieves muscular pain.

The anabolic and tonic effects of the hormones in Plestran appear to be enhanced by combination so that small dosages are very effective. Combination also overcomes some of the disadvantages of therapy with a single sex hormone, such as virilization, feminization or withdrawal bleeding.⁵

Dosage: Usually one tablet daily; occasional patients may require two tablets daily, depending on clinical response.

Supplied in bottles of 100 and 500.

References: 1. McGavack, T. H.: *Geriatrics* 5:151 (May-June) 1950. 2. Masters, W. H.: *Obst. & Gynec.* 8:61 (July) 1956. 3. Kimble, S. T., and Stieglitz, E. J.: *Geriatrics* 7:20 (Jan.-Feb.) 1952. 4. Kountz, W. B., and Chieff, M.: *Geriatrics* 2:344 (Nov.-Dec.) 1947. 5. Birnberg, C. H., and Kurzrok, R.: *J. Am. Geriatrics Soc.* 3:656 (Sept.) 1955.

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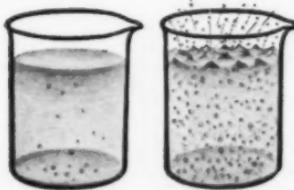
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(8 oz. glass of orange juice contains approximately 120 mg. vitamin C . . . half medium grapefruit, 75 mg. . . . medium tangerine, 25 mg.)

References

1. Morris, G. E.: A.M.A. Arch. Derm. & Syph., 70:363, 1954.
2. Bluefarb, S. M.: Post-grad. Med., 19:144, 1956.



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BUFFERIN contains no sodium, a marked advantage when cardiorenal complications make a salt-restricted diet necessary.

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References:

1. J. A. M. A. 159: 645 (Oct. 15) 1955. 2. J. A. M. A. 158: 386 (June 4) 1955.

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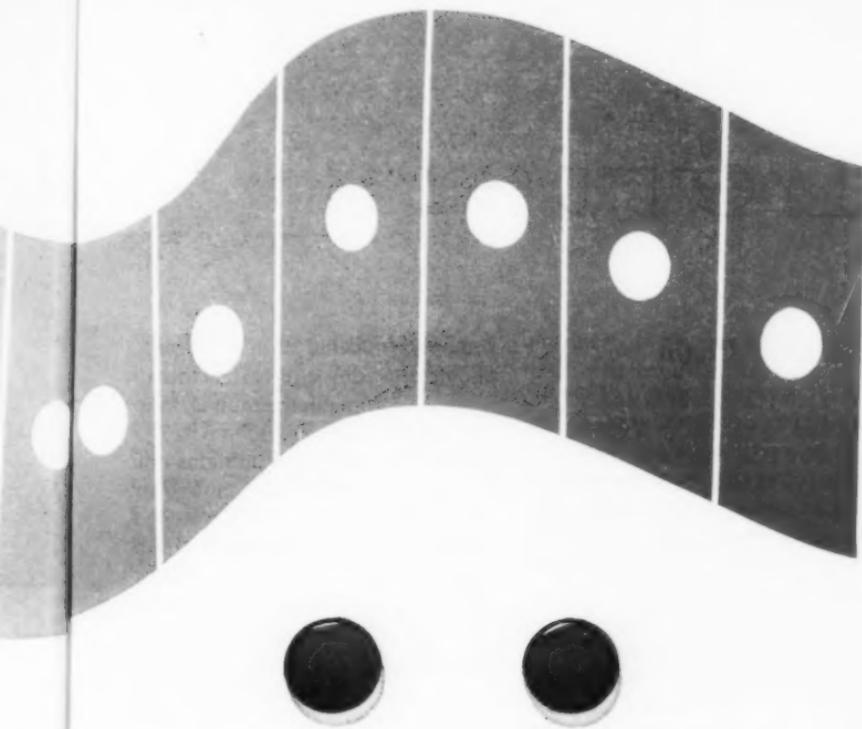
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Vilter¹ reported that a diet rich in the B-complex vitamins should be prescribed when treating nutritional anemia, because of the importance of the B complex to cellular metabolic functions.

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1. Vilter, Richard W., Am. J. Clin. Nut., 3:72, Jan.-Feb., 1955



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Letters

Internist's Plight

SIRS: If the present plight of the internist (i.e., nonrecognition by insurance carriers, labor, industry, and government) were to continue, it would end in only one way: The practice of internal medicine would vanish from the American medical scene.

That's why, as secretary-general of the American College of Physicians, I'm convinced that the formation of a new society of internists is a good thing. The American Society of Internal Medicine, which has been set up to deal with the economics of internal medicine, will play an important role in preserving the status of this country's internists. . .

Wallace M. Yater, M.D.
Washington, D.C.

Social Security

SIRS: One of your recent correspondents expresses violent disapproval of Social Security for doctors. He writes: "It appalls me to realize that a group of men, pre-

sumably educated and intelligent, should be willing to prostitute themselves by joining in the mob clamor for *panem et circenses*."

I say the American public is not a "mob." It's intelligent enough to know what it wants. We've watched one educated and intelligent group after another request compulsory Social Security coverage. About the only organized group still not covered is the medical profession.

H. L. Casebeer, M.D.
Butte, Mont.

SIRS: I read in your news columns that "one more state medical society has started offering special help to the families of deceased members." I'm sure the members mean well. But don't they realize that physicians' widows might prefer not to depend on that sort of aid? . . .

The profession makes heavy demands on a physician's wife. Very often she's asked to assist with secretarial and other duties in her husband's office. Yet if she becomes

widowed, she may have to depend on the charity of a medical society. Why? Certainly the doctor's wife should have the same protection as his nurse and other assistants: namely, Social Security. . .

A poll of self-employed doctors' wives might convince the A.M.A. that we want *compulsory* coverage.

Catherine M. Dance
Brooklyn, N.Y.

Malpractice Rx

SIRS: Overgenerous judges, weeping juries, and "selfless" lawyers have swelled the malpractice racket to a point where the medical profession is being buffeted by inquisition and legal blackmail. Too few corrective steps have been taken by our medical organizations. They'd do well, I feel, to promote the following suggestions:

1. Panels of lawyers and physicians should be appointed by the courts to screen every malpractice claim and decide whether it should go to trial.

2. Fee splitting between lawyers

and their clients should be prohibited. A schedule of fees for legal services should be established, and contingent fees should be banned.

3. The costs of court proceedings and the fees of *both* attorneys should be paid by the losing side.

4. Any doctor who makes defamatory remarks about another physician or his work should be disciplined by his medical society.

Herman Schauder, M.D.
New York, N.Y.

Doctors' Earnings

SIRS: Thank you for your eye-opening comparison of the "wealthy" doctor's income with that of the poor, laboring bricklayer. I get tired of hearing how much money we make—especially since we don't get all we earn. It's time we started defending ourselves by pointing out how labor's repeated demands raise *our* cost of living. . .

G. H. Hoerner, M.D.
York, Pa.

SIRS: Your survey figures on ten

LETTERS

unusually large medical practices are both interesting and understandable, with only one exception: the Michigan G.P. who claims to have grossed \$105,000 and to have worked only thirty hours a week in the process.

Even with 100 per cent collections and no vacation, this amounts to \$67 an hour. Do you really think one G.P. with only three aides can gross that much?

William R. Hunt
Management Service for Doctors
Waco, Tex.

The doctor in question reports that he handles fifty patients a day. On the basis of a six-day week, this amounts to ten patients an hour.

Thus his return per patient visit averages \$6.70. These aren't inconceivable figures if you assume that some or all of his three aides are R.N.s who give injections, take X-rays, and provide other income-producing services that cost the doctor nothing in time.

—ED.

Fluoridation Failure

SIRS: You report that Spartanburg, S.C., plans to skirt "violent differences of opinion" on fluoridation by supplying free sodium fluoride tablets to residents who want them. But experience with similar programs in Newark, N.J., and other communities indicates that many



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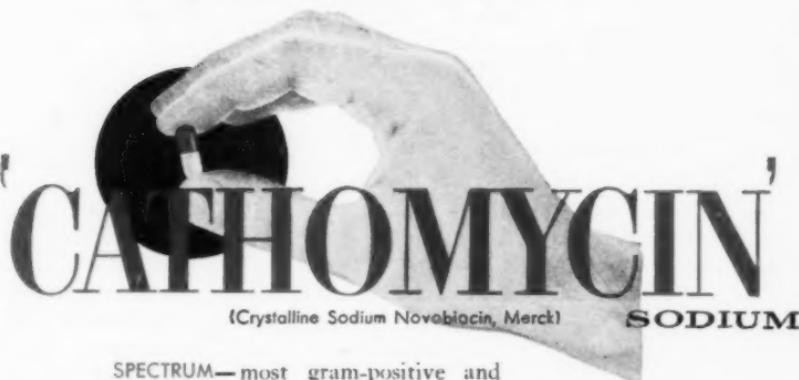
Sustained

*Usual dose: Just 1 tablet upon arising and one before the evening meal. Bottles of 50 tablets. THOS. LEEMING & CO., INC., 155 East 44th Street, N.Y. 17, N.Y.

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**a unique new antibiotic
of major importance**

**PROVED EFFECTIVE AGAINST
SPECIFIC ORGANISMS
(*staphylococci and proteus*)
RESISTANT TO ALL OTHER
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SPECTRUM—most gram-positive and certain gram-negative pathogens.

ACTION—bactericidal in optimum concentration even to resistant strains.

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ABSORPTION—oral administration produces high and easily-maintained blood levels.

INDICATIONS—cellulitis, pyogenic dermatoses, septicemia, bacteremia, pneumonia and enteritis due to *Staphylococcus* and infections involving certain strains of *Proteus vulgaris*, including strains resistant to all other antibiotics.

DOSAGE—four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

SUPPLIED—250 mg. capsules of 'CATHOMYCIN', bottles of 16.

'CATHOMYCIN' is a trademark of Merck & Co., Inc.



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LETTERS

parents don't bother to obtain the free tablets, even when their availability is widely publicized...

The avoidance of controversy doesn't seem like a good enough reason for side-stepping a medical responsibility. In many health matters, the people who need protection most are the least ready to secure it.

Benjamin Spock, M.D.
Cleveland, Ohio

Tax Morality

SIRS: I agree wholeheartedly with Cameron Hawley's "Who's a Tax Evader?" I too want to go back to ethical and moral standards of Federal taxation.

But how do we start? For whom do we vote?

R. S. Jaggard, M.D.
Oelwein, Iowa

Reactions to 'Medicare'

SIRS: "Medicare" is a leak in the dike. In time, this medical program for military dependents will be broadened until it becomes a torrent of tax-financed, Federally enforced medical care—in other words, socialized medicine.

W. L. Baughn, M.D.
Anderson, Ind.

SIRS: ... It's no longer a question of forestalling socialized medicine, but rather of controlling our des-

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FELSOL provides safe and
effective relief in *Asthma, Hay Fever*
and related bronchial affections.

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Antipyrine 0.869 gm.
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The fast action and long duration of FELSOL gives smooth and comforting relief. After a single therapeutic dose of antipyrine, Brodie and Axelrod report, "Plasma levels declined slowly, measurable amounts of the drug persisting 24 hrs." (J. Pharm. & Exper. Ther. 98:97-104, 1950)

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Promethazine Expectorant with Codeine Plain (without Codeine)

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LETTERS

tiny *within* the socialistic structure. "Medicare" is our present answer to that problem.

Under the new law, physicians will still function as independent practitioners and receive adequate compensation for their work. Even though the Government pays that compensation, the process by which the amount and manner of payment is determined is controlled by our state medical associations. So the new program is a matter of private business, rather than Government business . . .

A. A. Lampert, M.D.
Rapid City, S.D.

SIRS: . . . Private medicine can

only gain by the "Medicare" program. It provides the independent physician with all the safeguards he could want. I anticipate that the new law will be met with enthusiasm, cooperation, and a complete absence of abuse.

T. K. Callister
Comdr., M.C., U.S.N.R.
U.S. Naval Advanced Base
Bremerhaven, Germany

SIRS: James E. Bryan's recent article, "How You'll Treat Military Dependents," said that the "Medicare" law offers dependents "free-choice civilian care *only* in locales where military facilities aren't adequate." Actually, the law says that dependents have free choice at all

FOR TOPICAL INFECTIONS... ANTIBIOTIC-ANTIFUNGAL PROTECTION

BIOTRES

TRADEMARK



triple antibiotic and fungicidal ointment with an extended range of effectiveness against primary and secondary pyoderma. Provides optimal therapeutic amounts of zinc bacitracin, neomycin base (as sulfate), polymyxin B, and benzalkonium chloride for additive and synergistic effects with little likelihood of sensitization, bacterial resistance, or fungal overgrowth.

Administration: Apply to infected areas 2 or 3 times daily.

The Central Pharmacal Company - Seymour, Indiana



to promptly stop severe nausea and vomiting . . .

AMPULS for your bag. For immediate control of drug-, disease- or irradiation-induced vomiting. Dramatic results often obtained in cases unrelieved by other antiemetics. 25 mg. (1 cc.) and 50 mg. (2 cc.) ampuls in boxes of 6.

SUPPOSITORIES. When oral doses cannot be retained and when injections are not practicable—these are the obvious answer. Rapidly absorbed. Two strengths: 100 mg. for adults, and 25 mg. for children.

SYRUP for pediatric use. Often one dose stops the vomiting of gastroenteritis. Each 5 cc. (1 teaspoonful) contains 10 mg.

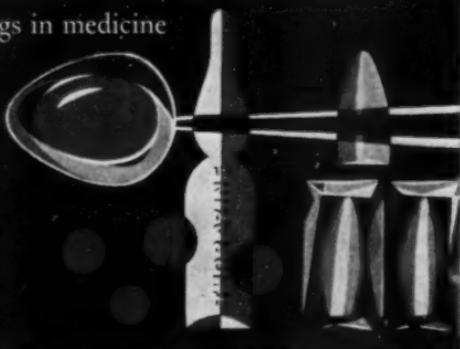
TABLETS when oral dosage is feasible. Available in 10, 25, 50 and 100 mg. tablets.

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one of the fundamental drugs in medicine



LETTERS

times, unless the Secretary of Defense limits their choice in areas where military facilities are adequate.

The Secretary has not yet invoked this restriction. Until he does, there is free choice in *all* areas.

Milo A. Youel, M.D.
San Diego, Calif.

SIRS: I feel that we doctors have made an unfortunate mistake in accepting a full-service plan for "Medicare." The negotiated fee schedules will be used as a basis for setting fees throughout America. They'll cause labor unions to demand similar full-service contracts.

In my opinion, this plan constitutes the first definite inroad into the free-enterprise system of medicine as we've known it.

R. W. Kimbro, M.D.
Cleburne, Tex.

Hospital 'Dictatorship'

SIRS: According to your recent news item, "Memphis doctors are up in arms over what an editorial in the Memphis Medical Journal calls the insulting 'dictatorship' of local hospitals."

For my part, I'm wondering why the doctors aren't critical of the Journal's editorial, rather than of the hospitals' insistence on good medical records.

Physicians shouldn't object to any staff regulation, however oner-

ous it may seem, provided it contributes to the patient's welfare . . .

R. A. Bartholomew, M.D.
Atlanta, Ga.

SIRS: The "ultimatums" issued to local physicians by Memphis hospitals . . . are no more ridiculous than some of those laid down by a hospital in the town where I practice. For instance:

1. Phone calls to the records department are permitted Tuesday through Friday from 2 to 4 P.M. only.
2. No treatments may be given and no dressings may be applied during meal times.
3. One day's notice is required for changing a patient's diet.
4. Physicians who do any surgery are no longer permitted to admit medical patients.

This last decision has forced me to limit my hospital work to about ten major operations a year.

M.D., New York

The G.P.'s Burden

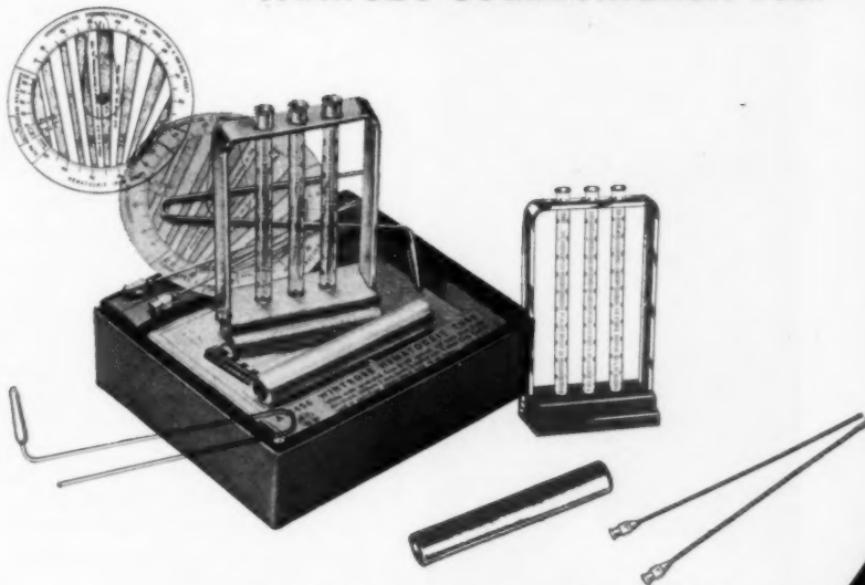
SIRS: After rereading "The Overburdened G.P.," I'd like to offer one constructive suggestion:

Dr. Walker seems to be making too many house calls. If he raises his house-call fee to twice the amount of his office fee, many patients who can't come in will soon stop calling him. This will result in a more equitable distribution of house calls among the available

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Compact, complete outfit for

Wintrobe Sedimentation Test



This is a complete kit for Wintrobe hematocrit and sedimentation tests—with Dr. Best's Calculator for rapid and simple correction of Wintrobe Sedimentation rate.

With the kit comes a stainless steel syringe cannula, permitting use of the same syringe for taking of blood sample and for filling the Wintrobe tube.

The Physicians Outfit for the Wintrobe Blood Sedimentation Test provides all the apparatus necessary for performing these tests in a physician's office. Note: the ADAMS Safety-Head Centrifuge (CT-1002) is recommended for use with this test as fulfilling the centrifugal force requirements.

The complete kit contains:

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- Adapters (2) for centrifuge shield to hold Wintrobe Tubes
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- Syringe Cannulas (2) for Wintrobe Tubes

A-2448 Physicians Outfit for the Wintrobe Blood Sedimentation Test, including equipment listed above, complete with directions, each \$15.00.

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lower blood pressure WITHOUT JOLTING

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when blood pressure
must drift down...not plunge

NITRANITOL with

PHENOBARBITAL

Dosage: In blood pressures over 200 systolic, 2 tablets four times daily. In other cases, 1 or 2 tablets every four to six hours.

Supplied: Bottles of 100 and 1,000.



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LETTERS

physicians. And it will relieve Dr. Walker of some of his burden.

W. M. Avent, M.D.
Waco, Tex.

SIRS: . . . In my opinion, the most important single change Dr. Walker could make would be to get back on more of a daytime basis. He should discontinue evening office hours, except perhaps on Fridays. He might even be able to do without Friday evening sessions if he could make arrangements with most of his working patients to see them late in the afternoon . . .

Frank W. Switzer
Professional Management Corporation
Denver, Colo.

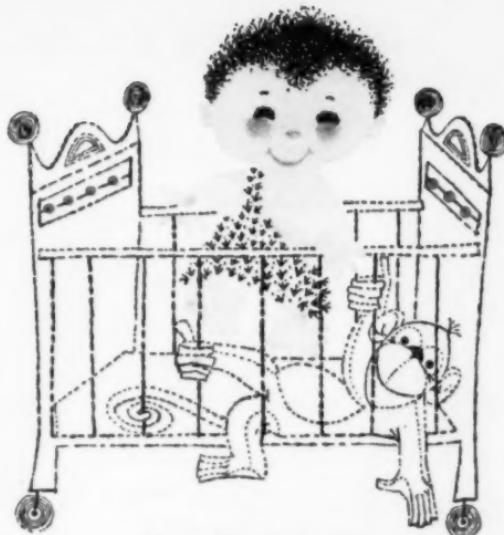
SIRS: . . . Dr. Walker's income is mainly from obstetrics. In my area, this is such a poor source of income that many of my colleagues have stopped handling OB cases.

The explanation seems to be this: Most of the local people are either just starting families or else already have large ones. In either case, they plead lack of money.

The doctor may collect up to \$35 early in the patient's pregnancy—but in many cases that's all he collects. The baby is delivered with the account still owing. Then the family picks up and moves out of the state.

Maybe your "overburdened" G.P. is much better off than he realizes!

Robert A. Heebner, M.D.
Compton, Calif.
END



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10 nutritionally significant vitamins • delicious fruit flavor • no unpleasant aftertaste • assured stability including B₁₂ • full dosage assured—can be dropped directly into baby's mouth • no refrigeration required • in 15 cc., 30 cc. and economical 50 cc. bottles with calibrated, unbreakable plastic 'Safti-Dropper'

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Patient: "H.M., a 53-year-old grandmother, suffered from pronounced weakness, nervous depression, complained she was 'always sleepy but could not get to sleep'...unable to organize her activities because she became melancholy and depressed."

Medication: 'Dexamyl' (S.K.F.)

Results: "There is no question that this patient's mood is relieved of its 'forceful tension'...she has less fear of the day's work; she lays out her various duties for the day with less apprehension. Her sleep-killing nervous depression is gone."

(From a case history by the patient's physician; unposed photos of H. M. taken during an office visit.)

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To relieve the 'forceful tension' of the nervous and depressed patient . . .

'Dexamyl'—a balanced combination of two mood-ameliorating agents—provides a unique "normalizing" effect which is free of the dullness sometimes caused by anti-anxiety agents alone, free of the excitation sometimes caused by stimulants alone.

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"Smooth and subtle improvement of mood."
"In days" there is
no better way to
relieve the 'forceful tension' of the
nervous and depressed patient . . .



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MAALOX® suspension, bottles of 12 fluidounces (*sample on request*); tablets, bottles of 100.

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Topical Salicylate Therapy
for safer, more effective
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High concentration topical salicylate-menthol therapy (BAUME BENGUE) offers safe, penetrating relief of painful joints and muscles caused by overexertion.

■ *Topical salicylate therapy is being rediscovered* as perhaps the safest, most effective remedy for aching joints and muscles.

Increased percutaneous absorption of salicylate, with enhanced blood flow through the affected tissue is provided by BAUME BENGUE, offering up to 2.5 times more methyl salicylate and menthol than other topical salicylate preparations. In arthritis, myositis, bursitis and arthralgia, BAUME BENGUE induces deep, active hyperemia and local analgesia.

Lange and Weiner suggest the term "hyperkinetics" to describe preparations such as BAUME BENGUE which produce blood flow through a tissue area. They point out that hyperkinetic effect, as measured by thermoneedles, may extend to a depth of 2.5 cm. below the surface of the skin. (J. Invest. Dermat. 12:263, May, 1949.)

Two strengths: *regular* and *children's*.

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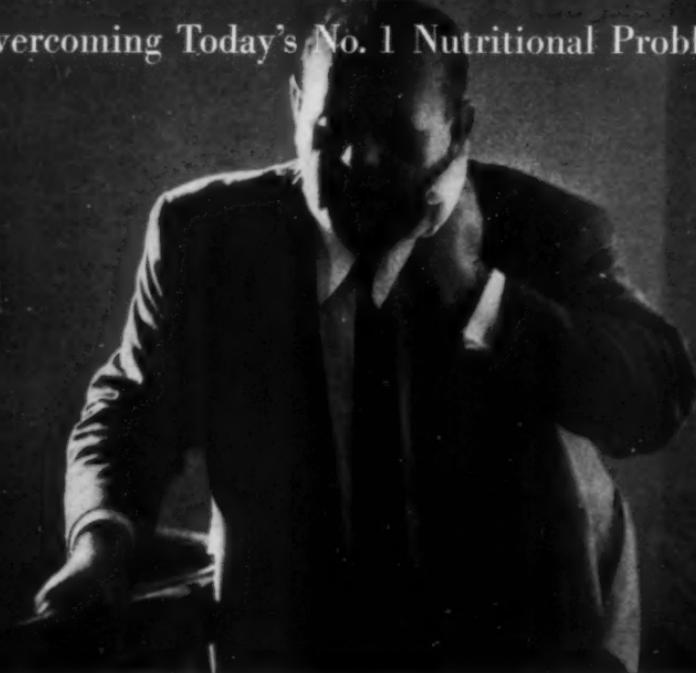
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Knox "Choice of Foods" Diet Can Help Your CARDIAC Patients Lose Weight Successfully



1. Color-coded diets of 1200, 1600 and 1800 calories are based on nutritionally-sound Food Exchanges.¹
2. Easy-to-use Food Exchanges (referred to in the Knox booklet as Choices) eliminate calorie counting by patient.
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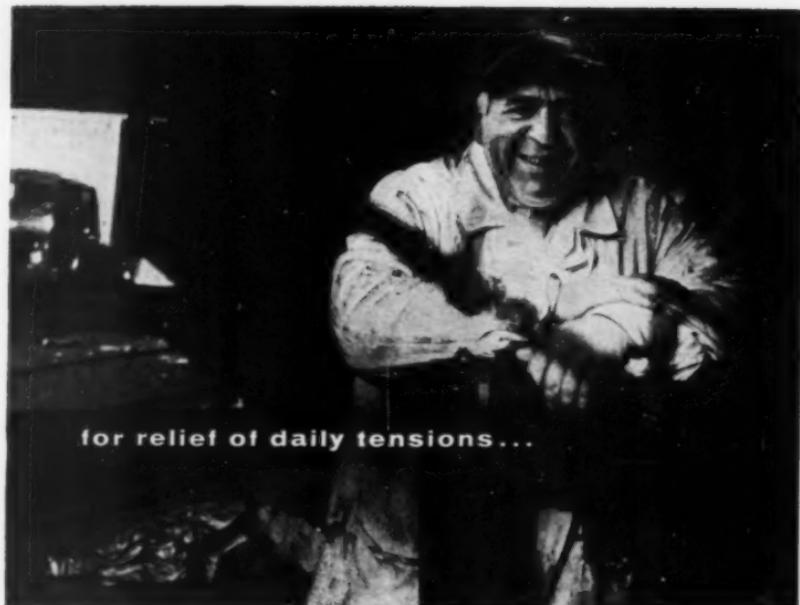
1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

- considerable latitude in food choice.
4. More than six dozen appetizing, low-calorie recipes are presented on the last 14 pages of each diet booklet.

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Please send me dozen copies of the new illustrated Knox Reducing booklet based on Food Exchanges.

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for relief of daily tensions...

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New and Different • not a hypnotic-sedative—unrelated to any available chemopsychotherapeutic agent • no evidence of cumulation or habituation • does not cause gastric hyperacidity • unusually wide margin of safety—no significant side effects

Dosage: 150-300 mg. three or four times daily.

Supplied: 300 mg. scored tablets, bottles of 48.

*Ferguson, J. T.: J. Am. Geriatrics Soc. 4:1080, 1956.



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It's probably that he has a frog in his pocket... but his mother also has a secret... she's going to have a baby.



This intelligent modern mother has placed herself in the care of the physician in whom she has implicit faith. Now, the Doctor may, and probably does, prescribe a number of different prenatal supplements to his patients for various but valid reasons.

It is quite possible, indeed probable, that the physician may consider the use of a phosphorus-free, aluminum hydroxide containing product. Especially if it also provides organic iron, Vitamin B12 with intrinsic factor, plus the *important* vitamins in the *new* levels suggested for pregnant or lactating women. There are only a very *few* such quality formulas available for his choice.

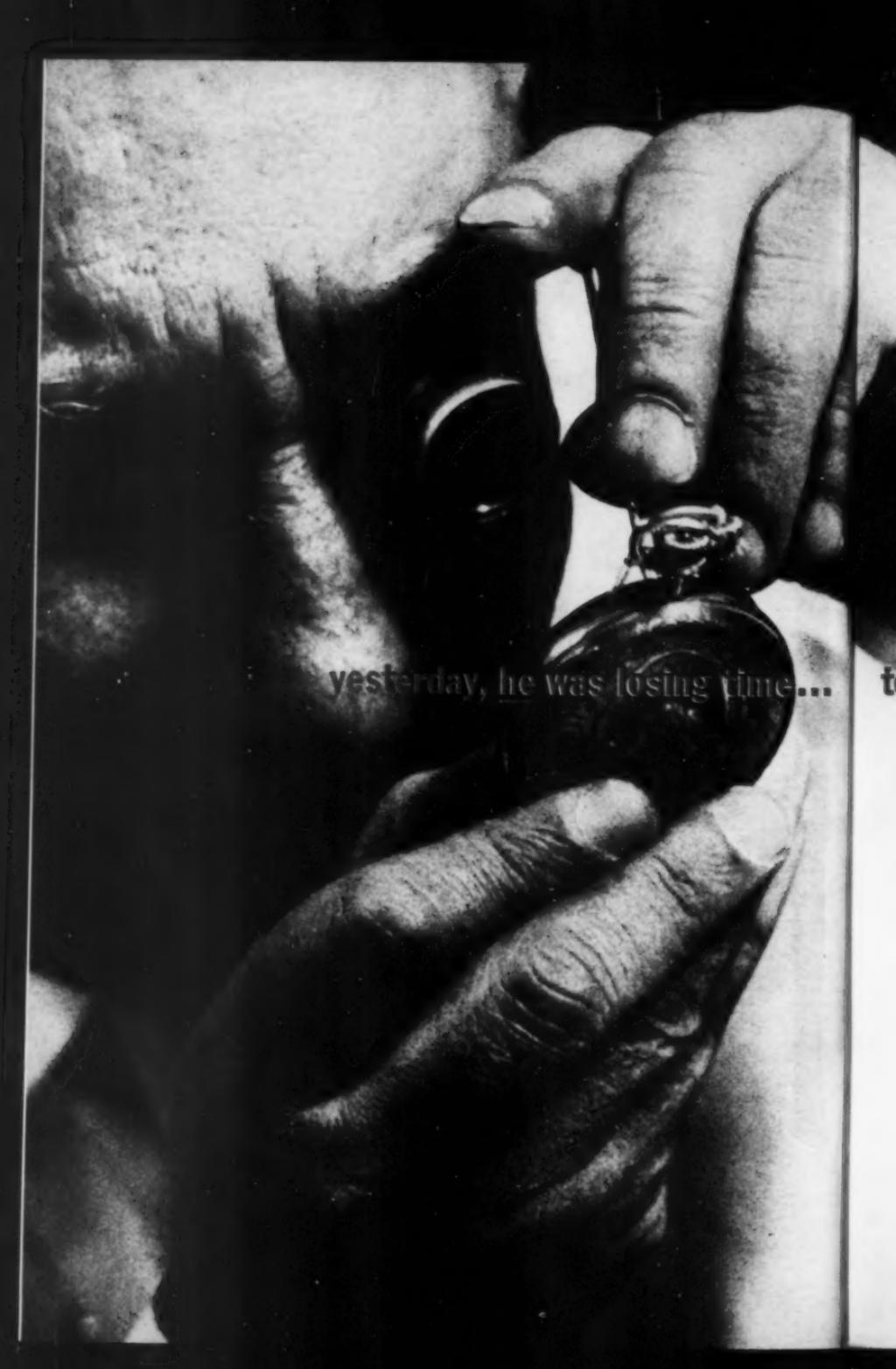
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Patient acceptance of these easy-to-swallow tablets (not capsules) is quite understandable. Incidentally, one of your obstetrical problems, "control of Cramps" will be relegated to one of very minor incidence by use of the product. For more complete information, samples and brochure write to

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yesterday, he was losing time...



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EXPECTORANT

When cough occurring with colds hampers on-the-job efficiency, your patients will welcome the promptness with which BENYLIN EXPECTORANT checks frequency and severity of cough, soothes irritation, and breaks up congestion. Because it contains the potent antihistaminic-antispasmodic Benadryl,^{*} in addition to demulcent and expectorant agents, BENYLIN EXPECTORANT gives equally dependable relief when cough is of allergic origin, or when sneezing, itching, or other allergic symptoms are complicating factors.

BENYLIN EXPECTORANT is without narcotic or central depressant action... may be administered to infants and children... and its pleasant flavor is acceptable to patients of all ages.

BENYLIN EXPECTORANT contains in each fluidounce:

Benadryl hydrochloride (diphenhydramine hydrochloride, Parke-Davis)	80 mg.
Ammonium chloride	12 gr.
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Anatomically correct rectal tube minimizes injury hazard . . . plastic squeeze bottle fits the hand, simplifies instillation . . . effective as soap suds, or more so,⁽¹⁾ FLEET ENEMA induces prompt, spasm-free evacuation.⁽²⁾

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Each 4½ fl. oz. unit contains, per 100 cc., 16 mg. sodium biphosphate and 6 gm. sodium phosphate.

(1) Swinton, N. W. Surg. Clin. of No. Am. 35:833, 1955

(2) Gross, J. M., Jl. Int. Coll. Surg. 23:24, 1955

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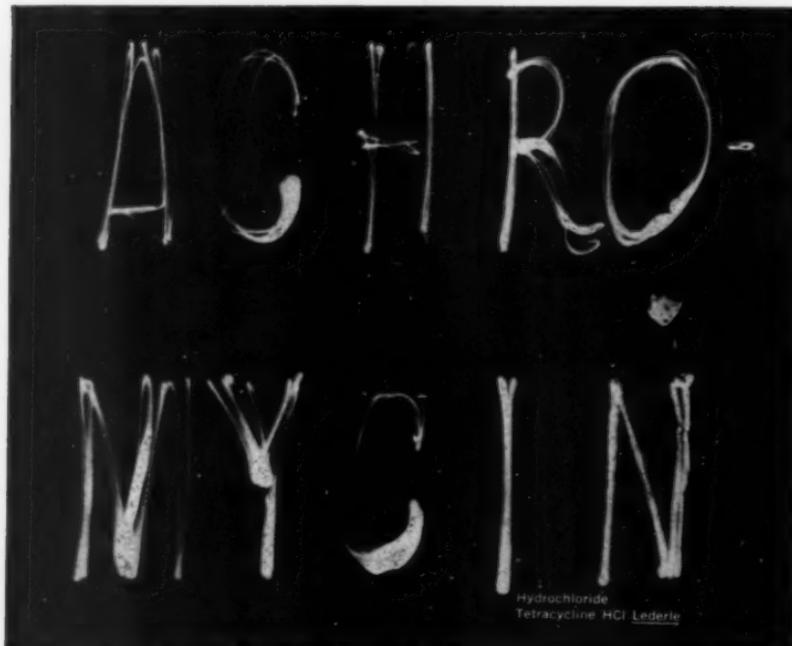
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*Trust Beech-Nut...
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Liquid Pediatric Drops

aqueous suspension

stabilized, soluble, no oil to block absorption, no oily taste or repeat, remarkably free of side effects

ready-to-use, no refrigeration

freely miscible in water, milk, formula, or drop directly on tongue

handy, plastic dropper bottle

accurate dosage is easy, one drop per pound body weight per day

Supplied: 10 cc. plastic dropper-type bottle (cherry-flavor), 100 mg./cc. (approx. 5 mg. per drop)

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ACHROMYCIN...ACKNOWLEDGED FOR COMPETENCE

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also in Delightful
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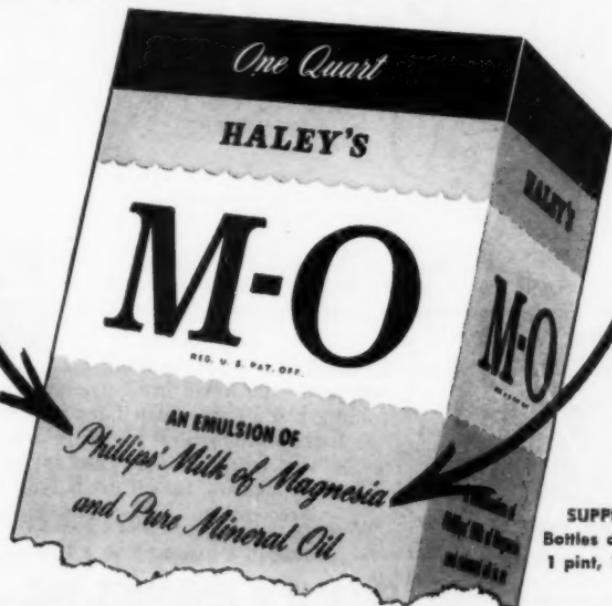
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The oil globules in Haley's M-O are minutely subdivided to assure uniform distribution and thorough mixture with intestinal contents. Oil leakage is avoided and a comfortable evacuation is effected through stimulation of normal intestinal rhythm and blunted defecation reflex.



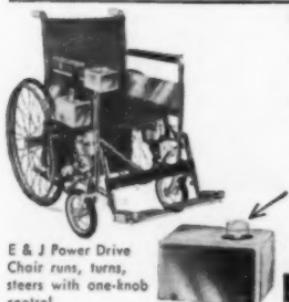
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MISS PHOEBE

NO. 11 IN A SERIES



"Surely you've seen *other* tourists
come here in E & J chairs!"



E & J Power Drive
Chair runs, turns,
steers with one-knob
control

Patients like to get out and rediscover the world in lightweight, folding E & J chairs. Their modern, good looks and effortless handling overcome "wheelchair shyness" and invite activity. In all sizes, for all needs, you can recommend an E & J with confidence.

There's a helpful E & J Dealer near you

EVEREST & JENNINGS, INC. LOS ANGELES 25

she's
been



HYFRECATED*



**not a blemish on her*

Desiccate those unsightly, possibly dangerous skin growths
with the ever-ready, quick and simple to use Hyfrecator.
More than 100,000 instruments in daily use.

**THE
BIRTCHER
CORPORATION**

Department ME-257

4371 Valley Blvd.

Los Angeles 32, California



*Please send me your new
full-color brochure show-
ing step-by-step techniques
for removal of superficial
skin growths.*

Doctor _____

Address _____

City _____ Zone _____ State _____



BEFORE: Female, 61 years. Severe itch in perirectal and vulval areas for 7 years. Area about rectum and vulva reddened and fissured; sensitive, painful, itching continuous. Moderate erythema.



AFTER: Hydrolamins applied 2 or 3 times daily. Itch and pain relieved first week. Within 3 weeks no irritation, erythema or itch.

STOPS

**the silent agony
of PRURITUS ANI
in 98% of cases***

Breaking the itch-scratch-itch cycle is essential to control of pruritus ani. Topically applied Hydrolamins Amino Acid Ointment relieves itch *with anesthetic speed*—but without danger of tissue reaction.

In a series of 100 unselected sufferers from pruritus ani, the author* reported "Relief... experienced immediately in 98 cases." Moreover, in 88% of cases, "Within a few weeks' time there is every appearance of normal skin."

HYDROLAMINS®

AMINO ACID OINTMENT

Hydrolamins offers an isotonic, specially selected combination of amino acids derived from lactalbumin in a vehicle of polyethylene glycol 1500. Hydrolamins buffers against local (bowel) irritants. It does *not* contain local anesthetics ("caines") or astringents.

SUPPLIED in 1 oz. (28 Gm.) tubes.

1911

PHARMACEUTICAL COMPANY

CHICAGO 14, ILLINOIS

*Bodkin, L.G., and Ferguson, E.A., Jr.: Successful Ointment Therapy for Pruritus Ani, Am. J. Digest. Dis. 18:59 (Feb.) 1951.



99% of your patients will say...

"Meritene® tastes good!" WHOLE PROTEIN SUPPLEMENT

(as good as ice cream!)

Why so much emphasis on taste? Because, simply stated, there is no value in any nutritional product—regardless how good the analysis looks—if it is not acceptable to the patient.

MERITENE Whole Protein Supplement is acceptable to patients because of its pleasant ice-cream-like taste. (Try it yourself!) And it's easy to prescribe, easy to administer, and economical for patients who use it at home.

MERITENE mixes with milk in seconds (and stays mixed) for ideal high protein supplementation. One 8-ounce MERITENE Milk Shake provides over one quarter the N.R.C. Daily Dietary Allowances for protein and all essential vitamins and minerals.

MERITENE has been widely used by doctors and dietitians ever since its introduction in

A product of

THE DIETENE COMPANY
MINNEAPOLIS 8, MINNESOTA

1940. Available at all drugstores in 1 and 5 lb. cans, chocolate or plain flavor. (Institutional size 25 lb. cans as low as 76¢ per pound on direct order from Minneapolis.)

MORE NUTRITIVE THAN EGGNOG	
8 oz. MERITENE MILK SHAKE	8 oz. EGGNOG*
Protein.....	17.0 gm.
Fat.....	1.0 gm.
Carbohydrates.....	38.5 gm.
Choline.....	4.0 mg.
Phosphorus.....	100 mg.
Vitamin A.....	3,000 I.U.
Thiamine.....	77 mg.
Riboflavin.....	1.84 mg.
Ascorbic Acid.....	100 mg.
Vitamin B ₆	1.0 mg.
Choline.....	25.4 mg.
Chromium.....	25.4 mg.

*Egg nog nutritional values from Bowes & Church, 7th Ed., 1951



ALSO AVAILABLE
NEW
INSTANT
MERITENE

FREE 1-LB. CAN—CLIP AND MAIL TODAY

MERITENE, c/o THE DIETENE COMPANY ME 27
3017 Fourth Ave. So., Minneapolis 8, Minnesota
Please send me a FREE one-pound can of INSTANT
MERITENE, plus a supply of comprehensive MERIT-
ENE Diet Sheets.

Name _____ MD

Address _____

City _____ Zone _____ State _____



Give youngsters what they need the way they like it... give 'em economical

WHITE'S COD LIVER OIL CONCENTRATE TABLETS

May be chewed like candy

New Improved Formula:

White's Cod Liver Oil Tablets now provide 4,000 U.S.P. Units of Vitamin A and 400 U.S.P. Units of Vitamin D per tablet--the equivalent of one teaspoonful of U.S.P. cod liver oil.

And for your older patients: high potency

WHITE'S COD LIVER OIL CONCENTRATE CAPSULES—

12,500 Units of Vitamin A and 1250 Units of Vitamin D.

WHITE LABORATORIES, INC.

KENILWORTH, N. J.

Life without Frenzy

He used to fuss and fume when traffic slowed him down. Now he relaxes—his pace of living has been "calmed down"—since his doctor prescribed

Butiserpine®

That's the tranquilizing-sedative-hypotensive effect BUTISERPINE has on tense, highstrung patients. Its *Butisol* component quickly induces a more reasonable, tranquil attitude. This gives the *reserpine* component a chance to build up to its maintenance tranquilizing effect.

Now you can prescribe Butiserpine also in its delightful Elixir form. Each tablet or teaspoonful of elixir contains:

Butisol® Sodium 15 mg. (1/4 gr.)

(Sodium 5-ethyl-5-sec-butyl barbiturate, McNeil)

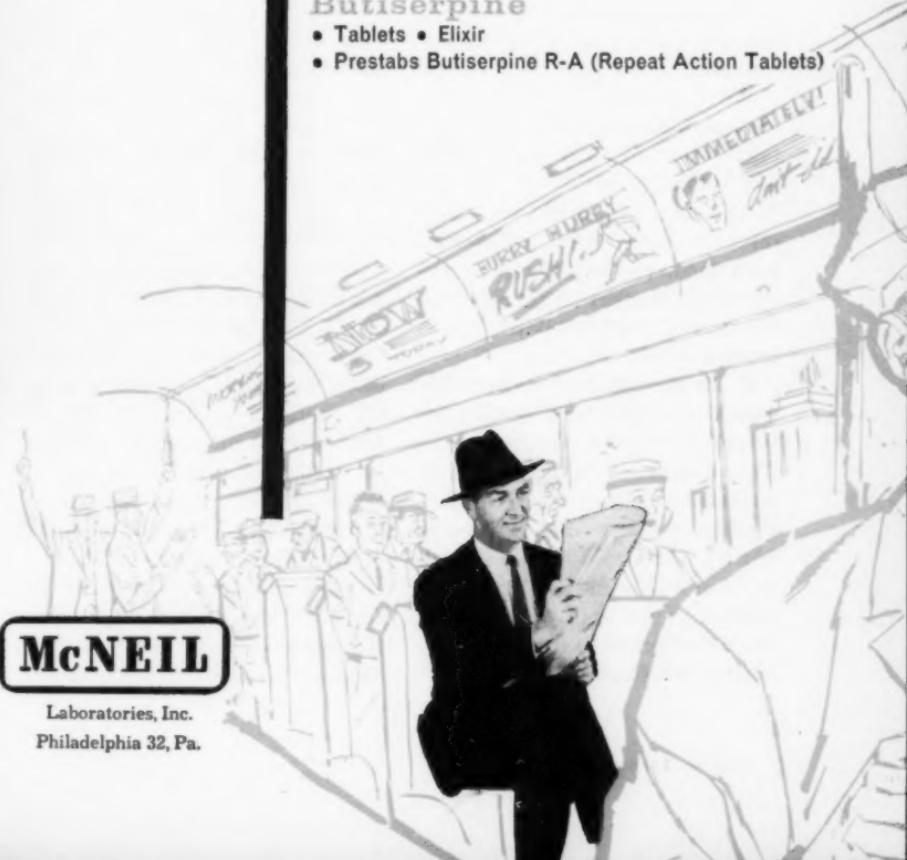
Reserpine 0.1 mg.

Butiserpine

- Tablets • Elixir
- Prestabs Butiserpine R-A (Repeat Action Tablets)

McNEIL

Laboratories, Inc.
Philadelphia 32, Pa.



Views

Outrageous Fees

There's plenty of room for honest differences of opinion on what constitutes a fair fee. But there's no room in medicine for fees that are outrageous by any reasonable standard.

We're talking about fees in the thousands of dollars charged to patients who obviously can't afford that kind of money.

Such fees are so illogical—and reflect such irresponsibility—that most doctors have difficulty believing the stories they sometimes hear about them. But the following three happen to be true:

¶ An allergist in an Eastern city treated a middle-aged woman for several years. He treated her for all sorts of disorders, real or imagined. And each year his charges climbed. Eventually the woman was being billed at the rate of \$4,000 annually. That's when the local grievance committee moved in. (The allergist has since been dropped from membership in his medical society.)

¶ A fellow of the American College of Surgeons performed a laminectomy on a graduate nurse. She didn't expect professional courtesy, but she did expect a reasonable bill. Instead, she was billed for \$7,000. (The surgeon is now a *former* fellow of the A.C.S.)

¶ Another surgeon's fee recently drew public whistles of astonishment from Dr. Isidor S. Ravidin, chairman of the A.C.S. Board of Regents. The fee was for a nephrectomy. Its reported amount: \$10,000.

Even when doctors know such stories to be true, they discount them a bit. They realize their rarity.

But the public doesn't. The exorbitant fees of a few doctors color lay attitudes toward *all* doctors' fees. Witness the most recent public opinion survey sponsored by the A.M.A. It found that almost half the people—43 per cent—think *most* medical fees are excessive.

What can doctors do about it? They can gradually let people know the going rates for most medical services, so that the few doctors

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who charge outrageous fees will be automatically exposed.

They can give full backing to grievance committees when they crack down on the culprits.

And they can avoid even the *appearance* of charging exorbitant fees by carefully explaining all variations from the norm.

Tax Break Ahead?

"The man who wants to retire on \$400 a month," says the Institute of Business Planning, "first has to accumulate \$100,000." That's the nest egg it takes to be sure of \$400 a month for life.

Sounds difficult, doesn't it? But if the man works for a company with a tax-favored pension or profit-sharing plan, building a nest egg of that size isn't as difficult as it sounds. In fact, the Institute reports:

"A man starting with a company at 25 and averaging an income of [only] \$4,000 a year will have \$100,000 accumulated for him in a [retirement] fund by the time he's

65. That's the magic of tax-free money compounded tax-free."

This magic, unfortunately, is denied the typical doctor. Unlike corporations, he can't earmark current earnings for pension purposes and thus avoid paying current taxes on the money.

One thing that would make it easier for him is the Jenkins-Keogh plan. This would defer taxes on the doctor's retirement savings. He'd be spared from paying any taxes on them until he drew them out after retirement—by which time he'd be in a lower income bracket with extra exemptions because of age.

In effect, the proposed legislation would give self-employed professionals the same tax break already enjoyed by workers employed by companies with pension plans.

The American Bar Association has started an all-out campaign ("Action in the 85th") to get the Jenkins-Keogh plan enacted during this session of Congress. The A.B.A. intends to "marshal the full strength of the legal profession behind the

VIEWS

principle of equal tax rights for the self-employed."

Individual physicians need to marshal their full strength behind it, too. The financial facts cited earlier show why.

Foolproof Follow-Ups

Plenty of doctors are still skittish about sending follow-up notices to patients. They're afraid their motives will be misunderstood. Yet they're well aware some patients ought to be reminded to come in.

Here's how one doctor we know has solved this problem. To selected patients he says:

"Would you like to be reminded

a few days before it's time for your next check-up? You would? Then suppose I give you this envelope. Please address it to yourself, then give it to my secretary. She'll mail a follow-up card to you at the proper time."

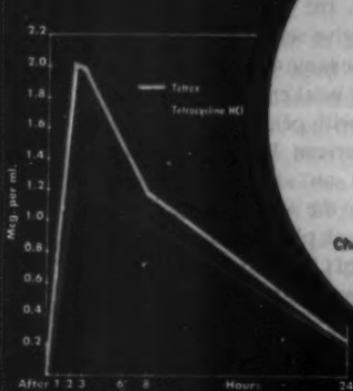
This puts the patient in the position of taking the initiative. And he's reminded of this later when the follow-up card arrives in the envelope bearing his own handwriting.

Health Insurance Query

"Doctor, how good is this health insurance coverage I've got?"

That's a familiar question wherever all types of health insurance

NOW... doubly-high antibiotic blood levels with



Hours	Tetr (mg per ml)	Tetracycline HD (mg per ml)
0	0.0	0.0
1	1.8	1.8
2	2.0	2.0
3	1.8	1.8
6	1.2	1.2
8	1.0	1.0
24	0.2	0.4

Chart (left) shows blood levels practically double with Tetracycline HD

— from 3 independent studies by P. A. Bunn, M.D., Sol Katz, M.D., and G. A. Cressi, M.D., on 200 patients

Tet TETRACYCLINE

are sold. And it's a tough question for the doctor to answer. He may not have all the facts. Even if he does, he may not want to sound partisan.

Several state medical societies have begun to take him off this hook. They're putting out pamphlets that help patients answer their own question. Excerpts from the Texas pamphlet (100,000 copies already distributed):

¶ "Watch...the policy which covers only specific diseases or special types of accidents... Big amounts like \$10,000 or more can be offered for little money for unlikely situations. But this is not good or adequate protection..."

¶ "Narrow limit benefits (such as \$5 to \$15) on such hospital services as operating room, laboratory, medicines, etc., are totally inadequate... Even a relatively high room benefit of \$7 to \$10 a day will not make up for such inadequacies..."

These pamphlets are fine as far as they go. But in our opinion, the individual doctor can go even further. As Dr. O. Norris Smith of Greensboro, N.C., suggests: "When the doctors in a community are convinced that a certain insurance is superior to others, their open support will soon guide their patients to better coverage. [Otherwise] much inferior health insurance will be sold; patients will suffer." [MORE ►

levels with a single antibiotic...*

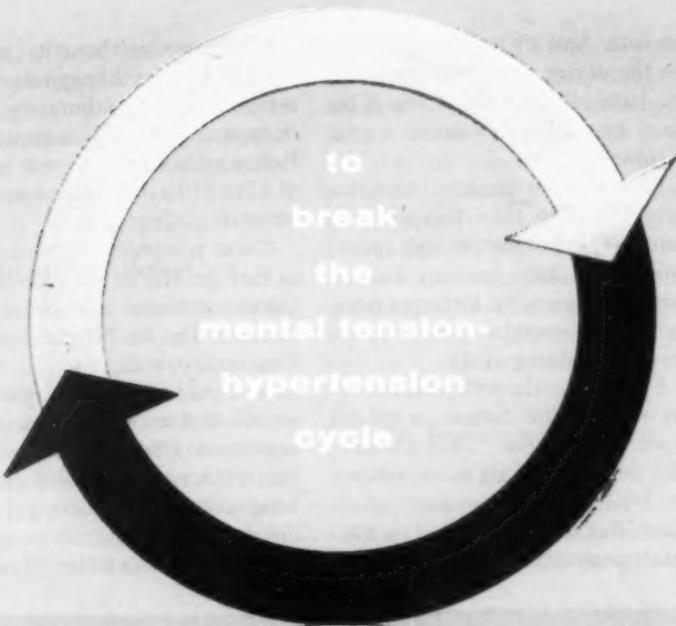
trexTM

OLINE PHOSPHATE COMPLEX CAPSULES

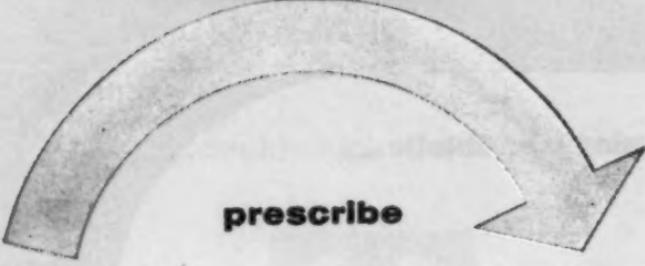
—each capsule equivalent to 250 mg. tetracycline HCl
—average adult dose 1 capsule q.i.d.

A new, single broad-spectrum antibiotic compound — providing faster, higher, more efficient blood levels, practically double those of tetracycline HCl, within 1 to 3 hours after administration.





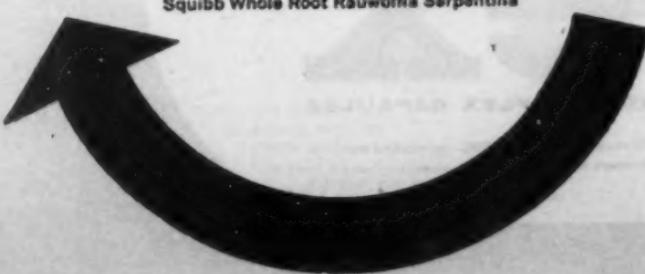
to
break
the
mental tension-
hypertension
cycle



prescribe

RAUODDIXIN

Squibb Whole Root Rauwolfia Serpentina



**Raudixin reduces
mental tension**

The tranquilizing effect of Raudixin helps cut the mental tension which always plays a significant part in essential hypertension, as well as the mental tension which is as yet unrelated to physical symptoms.

**Raudixin reduces
hypertension**

Raudixin also produces a gradual, sustained lowering of blood pressure in hypertensive patients, but does not significantly affect the blood pressure of normotensives. The hypotensive activity is not necessarily related to the tranquilizing effect of Raudixin.

DOSAGE

Two 100 mg. tablets once daily initially; may be adjusted.

SUPPLY

50 mg. and 100 mg. tablets, bottles of 100, 1000 and 5000.

SQUIBB



*Squibb Quality—
the Priceless Ingredient*

VIEWS

Doctors will suffer too, as long as patients buy policies providing inadequate allowances.

Pamphlets help. But plain talk helps even more.

Take-Home Pay

Union workers think of their income in terms of take-home pay. Doctors should, too, as we see it.

The typical self-employed physician—if he felt like it—could say proudly to himself: "My earnings came to more than \$25,000 last year." And he'd be right. According to MEDICAL ECONOMICS' 8th Quadrennial Survey, he grossed exactly \$25,016.

Yet how thoroughly that man may be misleading himself! Only by spending some \$9,000 for overhead can he take in that much. He'd be more realistic, therefore, to keep reminding himself: "My net income runs around \$16,000."

Even this figure isn't as realistic as *net income after taxes*—the equivalent of the worker's take-home pay. For the typical self-employed physician, it's roughly \$13,000, or only about half the first figure.

Sure, we all like to put the best possible face on our own economic performance. But the doctor who thinks in terms of his after-taxes net will be saving himself budget trouble all along the line. END

DR. J. A. L. L. M.D.
7 Louise Place, Brooklyn, N.Y.
733400 734400
PATIENT

R

NEO-MAGNACORT* *3.00*
neomycin and ethamicort

Sig. apply locally b.i.d.

John J. Johnson M.D.

Pfizer Laboratories

**trademark*



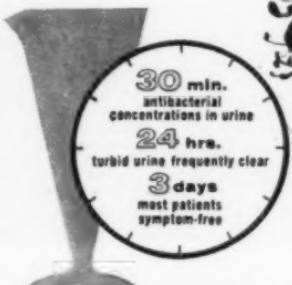
PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York

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in
pyelonephritis
delay is
dangerous...



FURADANTIN®
BRAND OF NITROFURANTOIN

first...
for rapid eradication of infection

In the majority of 112 cases, FURADANTIN "was effective clinically, with a pronounced improvement, indicated by the appearance of the urine as well as by verbal commendation by the patient, within 24 to 36 hours . . . Some of these patients with seemingly impossible cases were cured of their infection."*

FURADANTIN *first* because of these advantages: a specific for urinary tract infections • rapid bactericidal action • negligible development of bacterial resistance • nontoxic to kidneys, liver and blood-forming organs.

AVERAGE DOSAGE: **ADULTS**—four 100 mg. tablets daily; 1 tablet during each meal and 1 on retiring, with food or milk. In acute, uncomplicated infections, 50 mg. q.i.d. may be prescribed. However, if patient is unresponsive in 2 to 3 days, increase dose to 100 mg. q.i.d. **CHILDREN**—5 to 7 mg. per Kg. (2.2 to 3.1 mg. per lb.) per 24 hours.

Tablets, 50 and 100 mg. Oral Suspension (25 mg. per 5 cc. tsp.).

*Stewart, B. L., and Rowe, H. J.: J. Am. M. Ass. 160:1221, 1956.



EATON LABORATORIES, NORWICH, NEW YORK

Nitrofurans—a new class of antimicrobials—neither antibiotics nor sulphonamides



does not give...

**a false
sense of
well-being**

**TABLETS, 0.1 mg., 0.25 mg. (scored), 1 mg. (scored), 2 mg. (scored), and 4 mg. (scored).
ELIXIRS, 0.2 mg. and 1 mg. per 4-ml. teaspoon.**



does give...

true
emotional
control

Serpasil®

(reserpine CIBA)

Serpasil provides more than euphoria—more than temporary escape from the stresses and strains that are actually a "normal" part of life. Rather, Serpasil sets up a "stress barrier" against anxiety and tension the patient would otherwise find intolerable. In a low, once-a-day dose Serpasil keeps out external pressures long enough for the emotionally disturbed individual, with your help, to deal calmly with his internal conflicts.

Although it is a first choice in hypertension, Serpasil does not significantly lower blood pressure in normotensive patients.

C I B A
SUMMIT, N. J.



***Will your new
Electrocardiograph give you
all these advantages?***

- sharp, precision tracings
- constant visibility of record
- flip-switch changing from lead to lead
- portability for office or bedside use
- continuous calibration of paper speed
- automatic base-line stability, to eliminate distortion of the tracings

Combine features such as these with the rigid engineering standards and handsome, modern design of Burdick equipment and you can appreciate the respect owners of the Burdick Direct-Recording Electrocardiograph have for their instrument. Convenient operation, precision construction and durable performance will convince you of the advantages of owning this outstanding Burdick unit.

BURDICK

Direct-Recording Electrocardiograph

See your Burdick dealer soon for a demonstration.

The Burdick Corporation



Milton, Wisconsin



GOOD TASTING

Stimavite®
Tastitabs®

STIMULATE { appetite
growth

... and with Stimavite Tastitabs you can prod lagging appetites and promote growth in younger patients, perk up the "picky" adult eater. Their delicious natural fruit flavor makes patient cooperation easy.

Each STIMAVITE TASTITAB contains:

L-lysine 15 mg. for amino-acid improved protein quality.
Vitamin B₁₂... 20 mcg. for appetite and growth stimulation.
Vitamin B₁..... 10 mg. for appetite stimulation.
Vitamin B₆..... 3 mg. for improved protein metabolism.
Vitamin C..... 25 mg. for better hemoglobin formation and
(as sodium ascorbate) nucleic acid synthesis.

For the younger patient who doesn't like to eat, or who eats out of balance, and for the adult who eats like a bird, one or two Stimavite Tastitabs daily, at mealtime. Can be chewed, swallowed whole, allowed to melt in the mouth, or dissolved in liquids.

Bottles of 30 and 100 Tastitabs.



Chicago 11, Illinois PEACE of mind ATARAX®

*Trademark

Now-An easy-to-handle adhesive that sticks



New Curity Adhesive unwinds with the same gentle pull right to the very end of the roll. No more wasting the last couple of feet because you can't get it off the roll. And—Curity stays fresh.



New Curity Adhesive is easy to remove—and it comes off clean. (No sticky mass left on skin.) And you can't put a less irritating adhesive on a patient.



New Curity Adhesive is easy to apply. Won't wrinkle or tangle—because it has proper "body." It's up to 53% stronger than USP requirements—yet even the tiniest student nurse can tear it.



You get these new qualities in every roll of Curity adhesive you buy.

Since the invention of adhesive tape, manufacturers have been faced with the problem of making a tape that was easy to handle yet would really stick.

Now, at last, after 4½ years of research, the Bauer & Black Laboratories have solved this problem. The result is **New Curity Adhesive** that combines ease of handling with high adhesive properties.

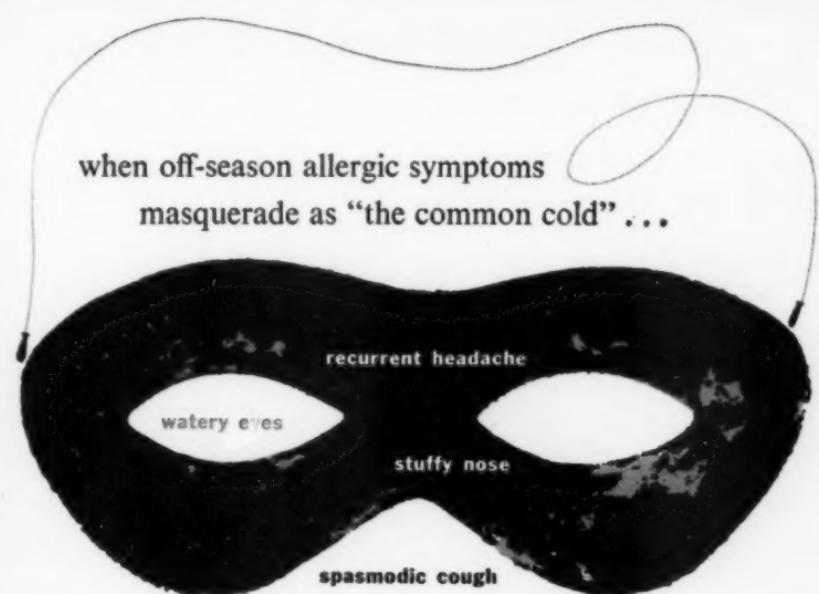
What's more, these balanced properties are built in to stay: a roll that's been in your drawer six months is just as fresh as one right from the factory.

NEW
Curity
ADHESIVE

BAUER & BLACK

Division of The Kendall Company

when off-season allergic symptoms
masquerade as "the common cold" ...



watery eyes
recurrent headache
stuffy nose
spasmodic cough

try **Teldrin*** 12 mg.  8 mg.

chlorprophénopyridamine maleate

Spansule*

sustained release capsules, S.K.F.

"the best method available for *antihistamine* medication"*

one easily remembered capsule q12h:

acts promptly
lasts all day and all night
well tolerated
convenient

made only by

Smith, Kline & French Laboratories, Philadelphia
first  in sustained release oral medication

*T.M. Reg. U.S. Pat. Off.

I. Rogers, H. L.: Ann. Allergy 12:266

MEDICAL ECONOMICS · FEBRUARY 1957 91



DRY, SCALY SKIN
DETERGENT RASH
SUNBURN
SIMPLE ECZEMA
DIAPER RASH
'DISHPAN' HANDS
PRICKLY HEAT
CHAFING

Superficial skin complaints usually respond dramatically to
TASHAN CREAM 'Roche'

Antiprurient, soothing, and healing—
contains vitamins A, D, E, and *d*-Panthenol,
in a cosmetically pleasing water-soluble
base which fastidious patients will enjoy
using. Hoffmann-La Roche Inc., Nutley, N. J.

TASHANTM

In urinary tract disturbances Pyridium® achieves the first objective

(Brand of Phenylazo-diamino-pyridine HCl)



relief of pain, urgency, frequency, burning
in a matter of minutes

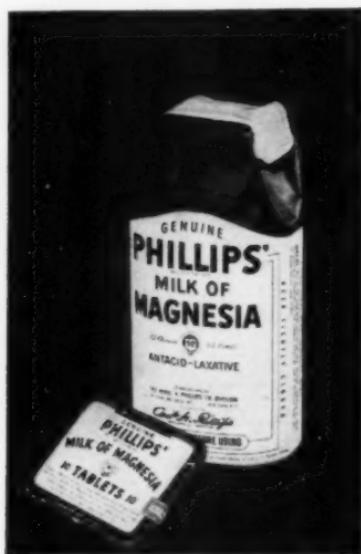
With PYRIDIUM, irritated urinary tissues are bathed in a continuous flow of analgesic fluid, keeping the patient comfortable during diagnostic procedures and while maintaining therapy. The benefits of therapy with PYRIDIUM include

- gratifying relief in a matter of minutes — long before specific therapy, if required, can take effect
- elimination of urinary retention due to pain spasm
- local analgesia only • complementary to any antibacterial of the physician's choice — allows separate control of analgesic and antibacterial therapy
- simple, convenient dosage — just 2 tablets before meals for adults.

Pyridium is the registered trade-mark of Nepera Chemical Co., Inc. for its brand of phenylazo-diamino-pyridine HCl. Merck Sharp & Dohme, Division of Merck & Co., Inc., sole distributor in the United States.

MERCK SHARP & DOHME • DIVISION OF MERCK & CO., INC. • PHILADELPHIA 1, PA.

An Ideal Antacid-Laxative



CONFIDENCE

In every field there are a very few products whose quality and demonstrated dependability over many years give them a position of pre-eminence over all others. It is this dependability which inspires confidence and universal acceptance of Phillips' Milk of Magnesia. Known and prescribed throughout the world for over 75 years.

PREPARED ONLY BY THE CHAS. H. PHILLIPS CO. DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N. Y.

PROVED...
in millions of doses
in millions of patients

Pentids

Squibb 200,000 Unit Buffered Penicillin G Potassium Tablets

just 1 or 2 tablets



Effectiveness and safety
confirmed by five years' experience
in millions of patients

Convenient t.i.d. dosage—may be
given without regard to meals

Economical for the patient—
far less costly
than newer penicillin salts

Bottles of 12 and 100 tablets

SQUIBB



Squibb Quality—the Priceless Ingredient

*PENTIDS® IS A SQUIBB TRADEMARK

for normal, healthy, comfortable pregnancies



PHOSPHORUS-FREE, HIGH-POTENCY
DRY-FILL* CAPSULES WITH "BUILT-IN"
ANTIANEMIA FACTORS

Walker LABORATORIES, INC., MOUNT VERNON, N. Y., U. S. A.

now with FLAVINOL
33.3 mg. per capsule

PATRICIAN

*a General Electric product
in step with your progress*



from radiography



... to fluoroscopy

... in a matter of seconds

—and those seconds are *split* in radiography with Patrician's stop-motion 200-ma, 100-kvp, full-wave power. Involuntary movements of patients or organs no longer need be your problem—nor the heavy investment formerly required for x-ray equipment capable of overcoming them.

At a price competitive with low-power, limited-range apparatus, you can now enjoy *full* x-ray facilities offered by the General Electric Patrician: kenotron-rectified output for longer x-ray tube life . . . 81-inch angulating table for those tall patients . . . double-focus rotating-anode tube for radiography and fluoroscopy . . .

highly maneuverable independent tube stand . . . fully counterbalanced fluoroscopic screen . . . compact, simplified control unit.

Before investing in x-ray equipment, get the complete Patrician story, including G-E financing plans. Use this handy coupon.

X-RAY DEPT.
GENERAL ELECTRIC CO.
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Send your 16-page PATRICIAN bulletin
 Facts about deferred payment
 MAXISERVICE rental

Name.....

Address.....

City..... Zone..... State.....

Progress Is Our Most Important Product

GENERAL  **ELECTRIC**

Erythromycin in Treating Pneumonia

A 27-year-old man, a chronic alcoholic, was admitted with a history of an alcoholic spree followed by a cough, greenish sputum and chills and fever.

Physical examination showed a temperature of 104 F. and indicated pneumonia in the right lower lobe. This was confirmed by X-ray. The sputum revealed gram-positive diplococci and blood culture subsequently grew Type VII pneumococci.

The patient was treated with erythromycin, 300 mg. every six hours per os. His temperature dropped to normal by 48 hours and X-ray of the chest revealed considerable clearing by the fourth hospital day. After 10 days hospitalization, the patient was fit for discharge.¹

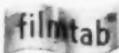
In the First Antibiotics Symposium, we reported the successful treatment with erythromycin of *H. influenzae* pneumonia and bacteremia. A second patient with *H. influenzae* pneumonia and bacteremia had a clinical course almost identical to the one previously reported, with cure obtained by treatment with 500 mg. of erythromycin per os every four hours for 14 days.

Of these 132 patients with bacterial pneumonia, 127 (96%) had a good clinical result. One patient with lobar pneumonia had a good initial response but had delayed resolution after treatment.

"Highly Effective in Pneumonia"

In one investigation, 75 adult patients with bacterial pneumonia were treated with erythromycin. In his summary, the clinician reported: "It is concluded that erythromycin is highly effective in the treatment of pneumonia due to gram-positive bacteria."²

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when you prescribe ERYTHROCIN. **Abbott**



Erythrocin®

(Erythromycin, Abbott)

STEARATE

"No Serious Side Effects Occurred"

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①Filmtab—Film-Sealed tablets, Abbott; pat. applied for.

1. Romansky, M. J., et al., *Antibiotics Annual 1955-1956*, p. 48.
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., *A.M.A. Archives of Internal Medicine*, 1954, p. 556.

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When May You Talk About a Patient?

Do any of the finer points of the confidential communications laws stick you? This question-and-answer article may get you off the hook

Many state laws agree with the Principles of Medical Ethics that you're duty-bound not to breach a patient's confidence. If you do talk out of turn about the clinical details of a case, you risk a lawsuit, censure by your colleagues, possibly even the loss of your license.

On the other hand, there are times when your duty to society supersedes your duty to the patient. If you *don't* talk at such times, you again risk being sued, censured, or deprived of your license.

When must you speak? When must you hold your peace? Even the courts haven't always agreed on the answers. But the hairline between "Talk!" and "Don't talk!"

THIS ARTICLE capsules the best thinking on confidential communications that the editors have been able to find. Its sources include James R. Rosen, M.D., LL.M.; Bernard R. Lauren, LL.M.; Stanley Neustadt, LL.B.; and Clinton DeWitt, LL.D., LL.B. Much of their material has appeared in different form and at different times in MEDICAL ECONOMICS; but the present round-up is especially enriched by many points Professor DeWitt has made in the Western Reserve Law Review (see his "Medical Ethics and the Law: The Conflict Between Dual Allegiances" in the 1953 fall issue of that journal).

WHEN MAY YOU TALK?

is by now fairly well drawn in the laws of the land—though sometimes it's almost invisible to the nonlegal eye.

The following queries have all been raised by practicing physicians. The answers are as precise as possible. Remember that state laws vary, and that what's true of the U.S. in general may not always be true in your locale.

Q. Suppose an insurance man asks about an applicant I've ex-

amined for him and his company. May I tell him what I've found out?

A. Certainly. When the applicant was sent to you, it was tacitly understood that you'd report back to the insurance company.

The same rule generally applies when you do a pre-employment physical examination for an industrial concern, a workmen's compensation examination, or a physical check-up on a veteran



"They took a dozen of mine to an O.B. man. And he ate 'em!"

who's claiming a disability pension. You can freely report the results to representatives of the interested organization.

Q. May I answer a welfare department's questions about an indigent patient I've treated?

A. As a rule, yes. The law generally recognizes that welfare authorities must have your report in order to learn how much medical attention the patient needs. By requesting treatment under such auspices and accepting it, the patient waives his privilege of secrecy to this extent.

Q. What may I safely tell a newspaperman who asks about the ailment of a socially prominent patient?

A. Nothing, unless you have a written release from the patient. Such a release should specify what information you may divulge.

Q. Is it safe to give medical information about a patient to organizations like the American Cancer Society or the Red Cross?

A. Not unless you can prove that revealing his condition is essential to the patient's well-being. Otherwise, better get a written release.

Q. A patient of mine was injured in an auto accident. The

insurance company for the driver of the other car has asked for a medical report. Should I give it?

A. Play it safe by getting the patient's permission. Only a few months ago a Milwaukee orthopedic surgeon was sued for \$50,000 because he'd overlooked the formality of getting a written release in a similar situation.

Q. If a patient refuses to pay his bill, or if I treat him free of charge, am I still bound by the secrecy rule?

A. Yes. In the eyes of the law, the doctor-patient relationship is not affected by failure to pay. (Nor, by the way, is it affected by the fact that a patient may have been unconscious at the time you treated him.)

Q. May I tell a wife what's wrong with her husband?

A. Better be careful: Such disclosures have a shaky legal basis, although in actual practice they seldom cause trouble.

Naturally, you're under a positive obligation to speak if any person has a contagious or mental disease that may endanger his family.

Otherwise it's usually best to tell the wife only what it's clearly in the patient's interest for her to know.

[MORE ▶]

WHEN MAY YOU TALK?

Q. *What if a police officer inquires about a patient I've treated?*

A. You're not required to tell him anything unless the patient has been shot or stabbed, or has suffered some other act of violence that must be reported under state or local law. In the absence of such a law, you should notify the police if you're treating an assault victim who seems likely to die. They may want to question him about the attack.

Q. *Should I notify the local authorities if I treat a woman who's obviously undergone a criminal abortion?*

A. A few states and communities require that such cases be reported. Doctors outside those jurisdictions are legally free to do as they think best.

Q. *I recently delivered an unmarried girl at her home. Must I report the birth?*

A. You may be subject to criminal prosecution if you don't. Your state undoubtedly requires you to report all births, deaths, and communicable diseases. (It may also require you to report such conditions as epilepsy, malignant tumors, occupational diseases, congenital defects, and narcotic addiction.)

Q. *A man came to me for treatment of a serious heart condition. When I discovered he was a bus driver, I warned him that he was endangering the lives of his passengers. But he has refused to quit his job. If I notify his employer, am I guilty of a breach of privacy?*

A. Probably not. But be prepared to prove you've acted in the public interest, and only after all other means have failed.

There's a famous Nebraska case bearing on this point. A doctor examined a patient for a skin rash, which he diagnosed as syphilis. He advised the patient to move from his hotel, so as not to infect other occupants of the building. When the man refused to move, the doctor warned the hotel-keeper that one of her guests had a "contagious disease." The patient was forced to leave.

Soon afterward, the diagnosis of syphilis was found to have been wrong. The patient brought suit.

But the Nebraska Supreme Court ruled that the physician had acted in good faith, from a sense of duty. He hadn't "willfully betrayed" a medical secret, said the court, even though his

disclosure was based on a diagnostic error.

Q. *Is it a violation of confidence if I turn my patients' records over to another doctor who has bought my practice?*

A. Probably not. But be sure each of your patients is notified in writing of the proposed transfer, so he can make other arrangements if he prefers. Ask him to sign your notice in a space provided, then to return it for your files.

In the Courtroom

Q. *Suppose I'm called by a third party to testify about a patient I've treated. Under what circumstances must I tell things he told me in confidence?*

A. The answer depends on where you live. In eighteen states* you can be compelled to testify about almost anything the patient told you. In four other states (North Dakota, Oklahoma, Oregon, and Pennsylvania) the privilege of secrecy is limited mainly to information "which shall tend to blacken the character of a patient." In the remaining twenty-

six states (plus the District of Columbia) you can't ordinarily be forced to discuss the clinical details of the case.

But no matter where you live, there are certain questions you've got to answer in court. You can be asked to testify about number of visits made, dates, fees, and other nonmedical details—about anything, in fact, apart from diagnosis and treatment. Here's a case in point:

A Midwestern doctor was called to a woman's home to treat her for a leg injury. While he was there, the husband shouted at his wife, "I'll kill you yet!" A few days afterward, the woman killed the man—in self-defense, she claimed.

In this case the doctor was allowed to testify concerning the husband's threat, since the information was not of a confidential, clinical nature.

Q. *Must I answer a subpoena, even though I'm certain I won't be allowed to tell what I know about the patient?*

A. Yes. Willful disregard of a subpoena is regarded as contempt of court.

Q. *If I'm to be called as a medical witness, may I go over my testimony with the patient's*

*Alabama, Connecticut, Delaware, Florida, Georgia, Illinois, Kentucky, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, Rhode Island, South Carolina, Tennessee, Texas, Vermont, and Virginia.

WHEN MAY YOU TALK?

lawyer beforehand? That is, may I confide medical facts to him, even though I'm not sure the judge will permit me to disclose them in court?

A. Yes. The lawyer is duty-bound not to reveal anything you tell him.

Q. *What should I do in court if a lawyer asks me a question that seems to involve privileged communications?*

A. Ask the judge for guidance. If he tells you to answer, you can do so without running the risk of a later lawsuit.

Q. *Are my clinical and hospital records privileged?*

A. Generally, yes, in those states that have privileged communications statutes. But in a few states, hospital records have been admitted as evidence, even though the attending physician hasn't been allowed to testify. It's worth remembering, too, that nurses, internes, technicians, and other assistants can occasionally be compelled to testify, unless the state's privileged communications law specifically includes them.

Q. *A patient gave me a progress report at a recent social get-together. Are such remarks privileged?*

A. The general rule is that the presence of a third person (apart from someone who's there to assist the doctor or patient) destroys the privileged status. If other people were listening, and if the patient knew it, his remarks cannot be considered confidential. But play it safe unless you're sure of these two ifs.

Q. *A patient is suing me for malpractice. Will I be allowed to discuss diagnosis and treatment in court?*

A. Certainly. By bringing suit against you, the patient has waived his privilege.

Q. *Suppose a patient of mine brings suit for negligence against another doctor. The patient's lawyer calls me to the witness stand. May I testify?*

A. Yes. The patient automatically waives his privilege by calling you as a witness.

Q. *Can I be compelled to testify about a deceased patient?*

A. It depends on where you live. In some states, the heir or beneficiary can waive the privilege. Elsewhere, only the patient himself can release the doctor from his obligation to secrecy; so once the patient's dead, the doctor's lips are sealed forever (except in a lawsuit over the patient's

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will, when testimony about his last illness may be called for).

Q. *How about testimony from a doctor who's done an autopsy?*

A. In some jurisdictions, the rule of privileged communications applies if the autopsy is performed by a doctor who treated

the deceased during his lifetime. Elsewhere, courts maintain that the doctor-patient relationship automatically ends when the patient dies. But if the doctor who does the autopsy never treated the patient, most courts allow him to discuss his findings. END



"Well, all I can say is it hasn't happened in 1,957 years!"



How to Save Some Money for Your Heirs

Will they get almost the full value of your estate? Or will they lose a quarter or half of it as a result of the transfer method you pick?

Unless you plan properly, estate taxes can take a big and unnecessary bite out of the property you will to your heirs. So if it appears that you'll leave assets worth more than \$60,000 (the point at which such taxes begin), it pays to start thinking about the transfer *now*.

This article describes some possible ways to transfer your estate. It points up the importance of selecting a transfer method that will give you the maximum in tax savings.

Using one method, for example, you could dissipate almost 44 per cent of your estate in taxes and administration costs. Using another method, you'd lose less than 5 per cent.

Of course, the exact percentages depend on your circumstances. The examples cited assume that you'll leave an estate worth \$300,000. They also assume that you're

THIS ARTICLE has been adapted from "Ten Ways to Transfer Your Estate," a booklet prepared by William J. Casey for the Institute for Business Planning, Inc., New York, N.Y.

married and have two children. Furthermore, in all cases illustrated below, it's assumed that you die before your wife does.

As figured here, the cost of transferring your estate to the next generation includes Federal estate and gift taxes, plus the typical state tax.



Method 1 43.8% Loss

You leave all your property to your wife in such a way that it doesn't qualify for the so-called "marital deduction." She in turn bequeaths it to your children.

Here we have maximum shrinkage. Reason: Your estate goes through two transfers and is fully taxed twice. You can avoid this by properly invoking the "marital deduction"—a privilege that lets you leave half the estate to your wife completely free of estate taxes.



Method 2 34.9% Loss

You leave your property to your wife outright, and she in turn bequeaths it to your children.

Here your estate qualifies for the marital deduction. So only half is subject to estate taxes when you die. But later,

SAVE SOME MONEY FOR YOUR HEIRS

when your wife dies, *all* the property is taxed before it reaches the children.



Method 3 **26.6% Loss**

You will the entire estate to a trust that pays the income from the property to your wife as long as she lives. Then, when she dies, the property itself goes to your children.

This used to be the most economical way to pass on an estate. But 1948 tax law changes made it a bit obsolete.



Method 4 **20.6% Loss**

You leave half your property to your wife outright. You place the other half in trust for your children, with the income going to your wife as long as she lives.

Half your estate (the portion placed in trust) is taxed at your death; and the entire estate is subject to administration costs. When your wife dies, her half is again subject to administration costs. It's then taxed, too.



Method 5 **18.0% Loss**

You leave your property to your wife and children in two equal trusts.

The property in your wife's trust qualifies for the mari-

tal deduction. So it goes untaxed at first. But when she dies, this property is taxed as it passes to your children. As for their own trust, it's taxed right away.

This method produces the same tax savings as Method 4. But, in addition, it saves administration expenses at your wife's death. What's more, it provides her with professional management of her property while she lives.



Method 6 12.7% Loss

Instead of setting up trusts in your will, you put all your property into a revocable trust during your lifetime; and you direct that it go to your wife and children as in Method 5 after your death.

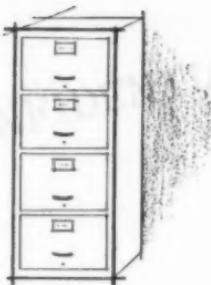
In a revocable trust, you retain the right to change the trust provisions at any time. So you can watch your plan in operation and revise it as necessary. At your death, your heirs benefit from big savings in taxes and administration costs.



Method 7 4.7% Loss

During your lifetime, you transfer one-third of your property to an irrevocable trust for your wife and children. You put the remaining two-thirds into a revocable trust (as in Method 6) and earmark it for your wife and children after your death.

The irrevocable trust removes one portion of the property completely from your control— [MORE ON 324]



Take a lesson from these

2. THE CASE OF THE

By Xavier F. Warren

EDITOR'S NOTE: This is the second in a series of true incidents selected from the confidential file of a malpractice insurance company's claims adjuster. Although names and identifying details have been changed, the stories remain substantially accurate portrayals of recent happenings. Each case highlights the danger of some form of haste or carelessness on the doctor's part.

My golf game at Birchwoods one Wednesday afternoon was interrupted by a phone call from Dr. Evans, one of our town's leading ophthalmologists. He was so worried that he'd insisted my secretary track me down. I turned in my clubs and went to see him.

It was one of those failure-to-warn-of-hazard cases. But here the hazard wasn't just a lost toe or a lamp-burned skin. It was blindness—total blindness in a 6-year-old boy. This is one of the most affecting cases, from the viewpoint of jury reaction, that a plaintiff's lawyer can latch onto.

Had Dr. Evans really failed in his duty to the patient? It didn't seem so to me. I was soon able to tell him that his case appeared defensible.

these malpractice mishaps!

THE MISSING EVIDENCE

But after further investigation I couldn't honestly reassure him as to the outcome. A piece of evidence that would have immeasurably strengthened his defense was missing. Here was the hitch:

The doctor had warned the child's family of the danger of a proposed operation. He had even kept a record of the warning. But in cases involving significant risks *this isn't enough.*

In all such cases, the hazards and possible consequences of the operation should be spelled out in specific detail—not just vague warnings. And as evidence that this has been done, the doctor should get a signed statement from the patient or his family.

Dr. Evans had missed out on this protective measure. And it was to cost him twelve months of trouble.

I'm no doctor, and I don't understand all the technical problems he faced. But here's how the trouble started, as I reconstruct it:

The child was blind in one eye before Dr. Evans saw him. In the other eye he had a congenital displaced lens. When it began to give trouble, Dr. Evans recommended an operation.

After the operation, the eye underwent degenerative

changes. Soon it was clear that the 6-year-old would never see again.

This is, I understand, a risk of the procedure. And Dr. Evans assured me he'd told the family the operation might not be successful. Even so, they'd agreed it should be done.

"I see," I said to the doctor. "You warned them of a chance of failure. Did you also state it in very precise words on the consent form?"

"Well, no," Dr. Evans replied. "I didn't want to alarm them unduly."

Now the boy's father was suing. "Do you suppose for one minute," the man claimed, "I would have consented to an operation that could lead to total blindness?"

The suit was for \$200,000. Dr. Evans had \$25,000 liability coverage. He was justifiably on edge about what would happen when the jury was confronted with a pathetically blind child.

It was more than a year before the case came to trial. During that time the ophthalmologist had to spend many hours with depositions and in preparation for the courtroom.

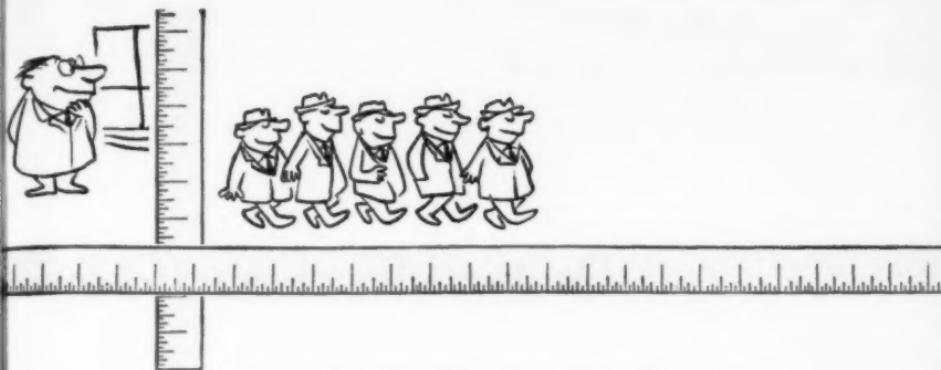
Then he had to take two full weeks away from his practice for the trial.

Fortunately, the final decision went our way. But even this happy ending didn't make up for the doctor's twelve unhappy months. And he could have been spared all the tense uncertainty and wasted effort if only . . .

Beyond doubt, the plaintiff's attorney would never have filed suit if the boy's parents had signed—and received a copy of — a consent form that spelled out the risk of blindness.

Dr. Evans now uses such forms in all cases of significant risk.

END



Yardsticks for Your Practice

*The sixth in a series of reports based on
MEDICAL ECONOMICS' 8th Quadrennial Survey,
to which 10,919 physicians contributed data*

How do your working hours and your patient load compare with those of your colleagues? The figures on the following pages will help you rate your practice on these counts.

Beginning next month, you'll get a series of economic profiles. The practices of the salaried doctor, the group doctor, the woman doctor, the general practitioner, and the specialist will be measured and analyzed in full financial detail.

Where are all these yardsticks figures coming from? The answer goes back to 1929, the year of the crash. That was when MEDICAL ECONOMICS made its first broad survey of the doctor's business. Every four years or so since then, it has made a still broader survey—a regular check-up of the profession's economic health that has no parallel for consistency.

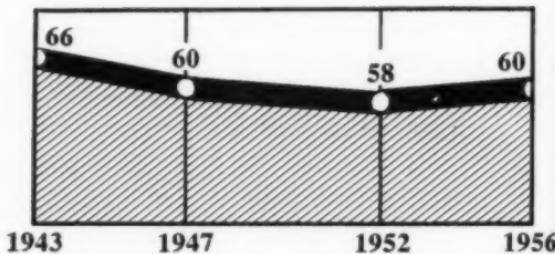
MEDICAL ECONOMICS' 8th Quadren- [MORE ON 326]

Doctors' Working Hours

For every eight hours the typical American works, the typical physician devotes twelve hours to the actual practice of medicine. This big differential—which explains so many other differentials—seems sure to get even bigger. Americans have begun to talk about the thirty-hour week at a time when the *medical* work week has lengthened to exactly twice that.

Doctors often think about shortening their work week

**The Trend in the Doctor's
Weekly Working Hours**



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Number of Hours a Week M.D.s Work

- 14% work at least 80 hours
- 33% work at least 70 hours
- 68% work at least 60 hours
- 70% work at least 50 hours
- 83% work at least 40 hours
- 94% work at least 30 hours
- 96% work at least 20 hours



[MORE ▶

by going into partnership practice. But a partnership doesn't seem to have that effect. Whether the doctor practices alone, in partnership, or in a group, his working hours are about the same. Nor do they vary much by income, region, or years in practice.

But working hours do vary according to field of practice, size of community, and number of patients seen daily. For example, the typical G.P. puts in about an hour a day more than the typical specialist.

The figures in the following tables are 1956 medians for self-employed physicians (those who get more than half their net income from fees for service). "Working hours" as used here refers to the hours actually devoted to medical practice.

How the Doctor's Patient Load Affects His Working Hours

Hours Worked Weekly	Patients Seen Daily
40 or more	70
30-39	60
20-29	60
10-19	54
Less than 10	48

**Number of Hours Worked Weekly
By Field of Practice**

General practice	60
Specialty practice	55



[MORE ►

**YARDSTICKS FOR
YOUR PRACTICE**

► Neurosurgeons devote more time to practice than M.D.s in any other specialty—20 per cent more, in fact, than the typical full specialist, and 10 per cent more than the typical G.P.

Hours Devoted to Practice

Allergy	45
Anesthesiology	54
Cardiovascular disease	55
Dermatology	42
Ear, nose, throat	50
Eye, ear, nose, throat	50
Gastroenterology	48
General surgery	60
Gynecology	50
Industrial practice	40
Internal medicine	60
Neurology	52
Neuropsychiatry	50
Neurosurgery	66
Obstetrics	50



Dermatologists, on the other hand, give about 25 per cent *less* time to practice than the typical specialist, and 30 per cent less time than the typical G.P. Pediatricians and internists work about the same number of hours a week as general practitioners.

Weekly in 30 Specialties

45	Obstetrics/gynecology	60
54	Ophthalmology	45
55	Orthopedic surgery	60
42	Pathology	55
50	Pediatrics	60
50	Physical medicine	48
48	Plastic surgery	60
60	Proctology	50
50	Psychiatry	50
40	Pulmonary disease	44
60	Radiology	50
52	Radiology/roentgenology	50
50	Roentgenology	44
66	Thoracic surgery	60
50	Urology	60



[MORE ▶]

YARDSTICKS FOR

YOUR PRACTICE

How Your Patient Load Compares

How the Doctor's Daily Patient Load Has Varied in Recent Years



Each complete figure represents five patients. This chart is based on averages, rather than medians, to permit comparison with previous years.

While the average physician now devotes more time to his practice than he did in 1952, he sees about 15 per cent fewer patients. Thus he spends more minutes with each.

How many patients *does* he see? The median figure is twenty a day. But one in every three M.D.s sees at least thirty a day. And one in twenty-five sees sixty or more.

Except where otherwise noted, the following tables show 1956 medians for self-employed physicians (those who receive more than half their net income from fees for service). The figures given are totals of patients seen in office, hospital, and home.

Percentages of Doctors Who Have Various Daily Patient Loads

- 2% see 70 or more
- 4% see 60 or more
- 6% see 50 or more
- 14% see 40 or more
- 31% see 30 or more
- 63% see 20 or more
- 91% see 10 or more

[MORE ►

YARDSTICKS FOR
YOUR PRACTICE

► Logically enough, the typical physician at the \$20,000 gross-income level sees about twice as many patients a day as his colleague whose gross is in the neighborhood of \$10,000. But the doctor earning four or five times as much as the \$10,000 man sees only about three times as many patients.

The typical M.D. apparently can handle up to fifteen patients a day without assistance. But he seems to need at least one office aide for every additional five patients he sees daily.

**How Many Patients Doctors See Daily
At Five Gross Earnings Levels**

\$50,000	30
40,000	30
30,000	25
20,000	20
10,000	11

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Doctors' Daily Patient Loads By Number of Aides

Number Of Aides	Number of Patients
3 or more	30
2	25
1	20
None	15



[MORE ►

YARDSTICKS FOR

YOUR PRACTICE

► The general practitioner's patient load is normally 25 per cent heavier than that of the typical specialist. Similarly, the doctor in a partnership or group generally sees about 25 per cent more patients than the man who works alone.

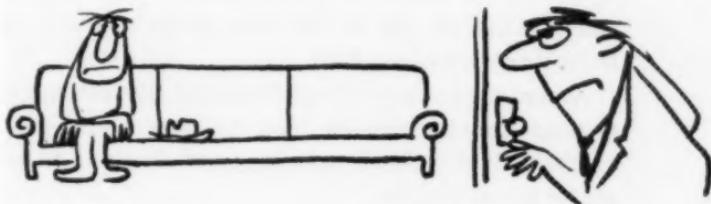
Broadly speaking, the smaller the town in which a physician practices, the heavier his patient load. The general practitioner with the heaviest daily patient load is likely to be the man in a town of under 25,000 population who's been practicing less than twenty-five years.

Daily Patient Loads by Type of Practice

General practice	25
Specialty practice	20
Solo practice	20
Two-man partnership*	26
Larger partnership or group*	25
All types of practice	20

*Per doctor.

Regardless of city size, the number of patients a doctor sees usually drops off somewhat after his twenty-fifth year in practice.



Number of Patients the General Practitioner Sees Daily By City Size and Years in Practice

City Size	Years in Practice			
	Under 10	10-24	25 or More	All Years
Under 25,000	30	30	20	30
25,000-499,999	25	26	22	25
500,000 and over	25	20	20	20
All city sizes	25	28	20	25

[MORE ►

YARDSTICKS FOR

YOUR PRACTICE

► Specialists with the heaviest patient loads are those in allergy and radiology/roentgenology. Specialists with the *lightest* patient loads are pathologists, anesthesiologists, and psychiatrists. All of the latter group typically see fewer than ten patients daily.

Among the six largest specialties, OALR/ALR men in medium-size cities see the most patients. And big-city specialists in psychiatry, neurology, and neuropsychiatry see the fewest patients.

Number of Patients Seen Daily in Office, Hospital, and

		Ho
Allergy	26	20
Anesthesiology	8	17
Cardiovascular disease	19	10
Dermatology	25	10
Ear, nose, throat	25	15
Eye, ear, nose, throat	25	20
Gastroenterology	15	20
General surgery	15	3
Gynecology	15	20
Industrial practice		
Internal medicine		
Neurology		
Neuropsychiatry		
Neurosurgery		
Obstetrics/gynecology		
Orthopedic surgery		
Pathology		
Pediatrics		

Daily Patient Loads of Physicians in the Six Largest Specialties by City Size

	Under 25,000	25,000- 499,999	500,000 And Over
Internal medicine	18	18	15
General surgery	20	20	15
Obstetrics/gynecology	20	22	20
Psychiatry/neurology	10	10	9
Pediatrics	20	25	20
OALR/ALR	20	28	20

and Home by M.D.s in Various Specialties

20	Plastic surgery	15
17	Psychiatry	9
10	Radiology	25
10	Radiology/roentgenology	26
15	Roentgenology	15
20	Thoracic surgery	15
20		
3	All other specialties	20
20		

END



Are Your Hospital Rights Well Protected?

It takes more than an M.D. on the governing board to guard your privileges; it takes a joint conference committee, says this author

By Charles U. Letourneau, M.D.

Dr. W closed the door softly and motioned me to a seat. "I've asked to talk with you privately because I want your honest advice," he said.

I nodded sympathetically. Although this was the first time I'd met him, I knew he was an outstanding general practitioner and a competent surgeon and obstetrician. What's more, he was president of his hospital's board of trustees.

Yet here he was, in a peck of trouble. His medical staff had passed a resolution condemning the hospital administration as unfit. His city's newspaper had demanded a public investigation. And now the hospital had called me in to help pick up the pieces.

Here's the problem as it looked to Dr. W.:
"My father built this hospital with his own money some

THE AUTHOR is a private consultant on hospital problems and a professor of hospital administration at Northwestern University.

forty years ago," he explained. "After I graduated from medical school, we operated it together as a proprietary institution. As its reputation grew and as other doctors moved into the area, we invited them to make use of its facilities.

"When my father died fifteen years ago, it became a nonprofit hospital. I was prevailed upon to become chairman of the board. Everything went well until about five years ago.

"That's when younger doctors began to move into town. They wanted to do major surgery, but we didn't think they were qualified. So we restricted their privileges. Now they're kicking up a fuss."

Dr. W paused to catch his breath. I used the occasion to ask: "Do you do major surgery?"

"Why, yes," he answered.

"Are you the only representative of the medical staff on the governing board?"

"Why, yes," he replied again.

I let him finish his story, then told him I'd explore the situation further. But I already had a pretty good idea of what the real trouble was: Dr. W had outlived his usefulness as medical staff representative on his hospital's governing board.

What I learned later confirmed my first diagnosis. The hospital had about forty doctors on its staff. About fifteen of these comprised the old guard. They considered most newcomers to be troublemakers—men who were unwill-

YOUR HOSPITAL RIGHTS

ing to serve an apprenticeship before attempting major surgery.

The young men, on the other hand, resented the old guard's "restrictive practices." As soon as they became numerically strong enough, they made their resentment public: They passed a resolution denouncing the administration. As a result, the hospital found itself in a virtual state of civil war.

It's Happened Before

An unusual situation? Not by any means. I've been connected with hospitals for a number of years, and I've run into similar problems dozens of times. The basic trouble is almost always the same:

The medical staff has only one channel of communication with the board of trustees: one or two fellow doctors who happen to be members of the board. And these one or two medical men can't be counted on to protect the hospital rights of *all* their colleagues.

Fortunately, there's a simple solution to this difficulty: The hospital need merely establish a joint conference committee on which doctors and trustees are equally represented. This committee's function is to thrash out

all outstanding medical and administrative problems, then to pass its recommendations on to the governing board.

Experience throughout the nation has shown that such a committee offers doctors their best protection against loss of hospital privileges. The joint conference committee also offers a first-rate means of helping medical staffs and governing boards to understand each other's problems.

Happily, the Joint Commission on Hospital Accreditation now *requires* hospitals to establish such committees in order to be accredited. But since only about 50 per cent of the country's hospitals have so far gained accreditation, a good many U.S. physicians still depend on an M.D.-trustee to protect their hospital rights.

Two Strikes Against Him

Why is such dependence likely to be untrustworthy? For two reasons:

¶ No matter how objective the doctor-trustee tries to be, he's always likely to interpret his colleagues' needs and desires according to his own needs and desires. If, like Dr. W, he's been

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appointed rather than elected to the board, he may well represent only one small faction of the medical staff.

¶ The typical doctor-trustee has too much power concentrated in his hands. He can pass judgment on both his own work and that of all the other physicians in his hospital. He helps decide on promotions within the medical staff. He helps allocate funds to the various hospital departments. He can thus unduly influence his own economic welfare and that of his colleagues. How can he be expected not to play favorites?

How It's Organized

The well-organized joint conference committee avoids both these pitfalls. But what, you ask, is a "well-organized" joint committee? In my work as a hospital consultant, I've found that such a committee always has the following basic characteristics:

First, it gives representation to *all* factions of the medical staff—and there may be as many as five such groups. The committee's physician-members are selected so that minority as well as majority factions have an effective voice in hospital affairs.

If any sizable segment of the medical staff lacks a direct pipeline to the trustees, trouble is almost sure to arise. I recently visited a hospital in the Southwest where there wasn't even a joint conference committee; the views of the medical staff were supposedly relayed to the board by two doctor-trustees. Both these physicians belonged to a group-practice clinic dominated by specialists. And their clinic was at odds with many of the area's solo specialists.

No personal rivalries were involved. But the rivalry between group specialists and solo specialists led the two doctor-trustees to become partisans. Eventually they persuaded the hospital board to restrict their solo competitors to courtesy privileges only.

Staff Voting System

When I was called in, it seemed clear to me that the medical majority wasn't being heard from. I advised the institution to set up a joint conference committee. Equally important, I recommended a special staff voting system.

End result? Proportional representation for [MORE ON 312]



Usual Fees in Three Areas

Now, for the first time, you can compare your fees for a whole spectrum of procedures with those of colleagues in other locales

By Arthur Owens

How do your charges compare with those prevailing in representative regions of the country? You can draw your own conclusions from the accompanying fee schedules. They show the usual charges for ninety-seven different medical and surgical procedures in three different areas: Erie County, N.Y.; Alameda and Contra Costa Counties, Calif.; and the State of Utah. None of these usual-fee indexes has been published before outside the area concerned.

Of course the *concept* of usual fees is far from new. Utah doctors developed a precursor of their present schedule nearly a decade ago. And doctors in many Colorado counties had partial indexes even earlier.

Why did physicians in Utah, in Erie County, and in Alameda-Contra Costa decide to establish virtually complete schedules of usual fees?

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Because they believed their charges would eventually be standardized anyway. They figured they had less to lose by standardizing fees themselves than by letting insurance companies and labor unions do it for them.

Note that these are *usual fees**—not uniform fees. The individual doctor may charge more if the case is complicated or if the patient agrees in advance. But in the absence of either advance agreement or complications, the doctor is expected to charge no more than the listed fee.

Obviously, this helps patients and their insurance carriers. Says Dr. James Graesser, chairman of the committee that drew up the Alameda-Contra Costa index: "It provides greater certainty of coverage for the patient without tying the doctor to a rigid fee schedule . . . It also gives Blue Shield and the commercial insurance companies a factual basis for determining their indemnities."

But does it also help doctors? Some medical communities still doubt it. Despite the impressive arguments for usual-fee indexes, you won't find more than a handful of medical communities that have them. Many doctors apparently fear that "usual" fees will be mistaken for uniform fees—that differences in doctors' skill, training, experience, and location will be lost sight of.

In the three areas under discussion, however, doctors, patients, and insurance companies now [MORE ON 146]

*Technically, the Erie County schedule shows "usual or customary" fees; the Alameda-Contra Costa schedule, "median" fees; and the Utah schedule, "average" fees. For simplicity, this article refers to all such listings as *usual fees*. The fee schedules themselves appear (condensed) on pages 138-144.

USUAL FEES IN THREE AREAS



OAKLAND, CALIF.

Which of These Three Usual-Fee

Your answer to the above question will guide you to the proper column of the fee schedules on the following pages. Here are the vital statistics you need:

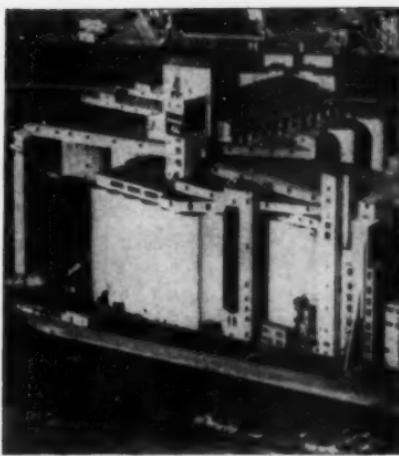
Alameda and Contra Costa counties, Calif., represent the booming West. They have more inhabitants, more doctors, and more money than the other areas studied. The combined population of 1,212,000 is concentrated around the Oakland side of San Francisco Bay. Most of the residents work in shipyards, chemical plants or factories.

There are 1,500 active private physicians in the area, or one for every 808 people. Sixty per cent are specialists. Their patients' effective buying power per capita: a high \$1,962.

Utah typifies sparsely settled states everywhere. Its population (786,900) is less than that of Erie County alone; there are only nine persons per square mile. Agri-



SALT LAKE CITY, UTAH



BUFFALO, N.Y.

Areas Is Most Like Your Own?

culture and mining are the major trades in this state.

Medically speaking, too, the state is less densely populated than the other two areas. It has 750 active private physicians, or one for every 1,050 people. Many doctors practice in Salt Lake City. Sixty per cent of them specialize. Their patients have the lowest effective buying power per capita (\$1,401) of any area studied.

Erie County, N.Y., typifies the urban East and Southeast. It's the most densely populated of the three usual-fee areas. Half its 1,002,500 population is concentrated in Buffalo, the world's biggest flour- and feed-milling center.

The county has 1,250 active private physicians, or one for every 800 people. Sixty-eight per cent of the doctors specialize—a higher percentage than in the other two regions. In per capita effective buying power (\$1,637), Erie County ranks right in the middle.

[MORE ►

Usual Surgical Fees in Three Areas

*Erie County, N.Y., State of Utah, Alameda
and Contra Costa Counties, Calif.*

Procedure	Erie	Utah	Alameda
Skin and Subcutaneous Areolar Tissue			
Biopsy			
	\$ 25	\$ 12	\$ 15
Excision of pilonidal cyst or sinus	150	168	125
Breast			
Excision of simple cyst or tumor	50	50	75
Mastectomy, complete (simple)	150	125	175
Radical	300	350	300
Musculoskeletal System			
Fractures, simple, closed reduction:			
Clavicle	60	60	50
Colles'	125	100	75
Fibula shaft	75	50	50
Metatarsal	50	50	35
Nasal bones	75	30	25
Ribs	40	38	35
Surgical neck of humerus	125	100	75
Tibia shaft	250	125	100
Vertebra process	50	50	50

USUAL FEES IN THREE AREAS

Procedure	Erie	Utah	Alameda
Respiratory System			
Antrum operation, radical (Caldwell-Luc)	\$150	\$150	\$200
Antrum wash	10	10	10
Antrum window operation	50	75	75
Bronchoscopy, diagnostic	50	75	60
Epistaxis control (primary nasal hemorrhage)	10	10	10
Ethmoidectomy, intranasal, bilateral	175	150	200
Lobectomy, total or subtotal	350	500	350
Septectomy, submucous resection	150	150	150
Thoracentesis	25	20	15
Cardiovascular System			
Ligation, division, and stripping of long saphenous vein and branches	150	125	125
Digestive System			
Anorectal surgery, including internal plus external hemorrhoidectomy, fissurectomy, cryptectomy, etc.	150	135	125
Appendectomy, adult	150	150	200
Cholecystectomy, with exploration of common duct	275	275	350

MORE ►

USUAL SURGICAL FEES (Cont.)

Procedure	Erie	Utah	Alameda
Digestive System (Cont.)			
Enterostomy, external fistulization of intestine (colostomy)	\$200	\$225	\$250
Gastrectomy, total	350	600	500
Herniorrhaphy, inguinal or femoral	150	150	150
If recurrent	225	150	200
Peritoneocentesis: abdominal paracentesis	25	18	15
Proctectomy, complete, combined with abdominoperineal resection	350	600	500
Proctosigmoidoscopy	25	10	15
Resection of large bowel, segmental	350	350	350
Retropharyngeal abscess, incision and drainage	50	50	25
Tonsillectomy, with or without adenoidectomy, adult	100	75	75
Child	75	60	60
Urinary System			
Cystoscopy, diagnostic	25	25	25
With ureteral catheterization	35	35	50
Nephrectomy	275	250	350
Male Genital System			
Circumcision, adult	50	50	50

USUAL FEES IN THREE AREAS

Procedure	Erie	Utah	Alameda
Orchiopexy, unilateral, complete	\$150	\$200	\$175
Prostatectomy, transurethral or perineal, subtotal	250	250	500
Radical	300	300	500
Female Genital System			
Bartholin's gland, incision and drainage of abscess	35	25	15
Cystocele or rectocele, repair	150	100	150
Both cystocele and rectocele, repair	250	200	200
Dilation and curettage	75	75	75
Hysterectomy, subtotal (supracervical)	200	200	250
Total (panhysterectomy)	250	250	300
Miscarriage or abortion, before period of viability (no surgery)	25	75	35
After period of viability, including dilation and curettage	75	100	75
Obstetrical delivery*	125-175	100-150	125
Caesarean section	200	250	150
Caesarean section with hysterectomy (Porro)	250	300	300
Endocrine System			
Thyroidectomy, total	250	300	300

*Includes prenatal and postnatal care. In Erie County, fees differ for general practitioners and specialists. In Utah, fees differ according to technique used.

[MORE ▶]

USUAL SURGICAL FEES (Cont.)

Procedure	Erie	Utah	Alameda
Nervous System			
Craniotomy for brain tumor, granuloma, scars	\$500	\$500	\$500
Lumbar puncture	20	12	15
Laminectomy, herniated intervertebral disc	275	250	350
Removal of spinal cord tumor	450	500	500
Splenchnicectomy	450	375	350
Subdural hematoma, drainage	200	250	250
Eye			
Cataract, extraction	—	10	10
Chalazion (Meibomian glands), excision	—	15	15
Ectropion, surgical repair	—	100	150
Entropion, surgical repair	—	75	150
Foreign body imbedded in cornea, removal	—	10	10
Ear			
Mastoidectomy, simple, unilateral	200	200	250
Radical, unilateral	250	300	350
Myringotomy (office)	15	15	10
Anesthesia			
First half-hour	17	20	20

USUAL FEES IN THREE AREAS

Procedure	Erie	Utah	Alameda
Second half-hour	\$11	\$15	\$10
Each subsequent half-hour	8	10	5
For obstetrical delivery	20	—	12

Usual Nonsurgical Fees in Three Areas

*Erie County, N.Y., State of Utah, Alameda
and Contra Costa Counties, Calif.*

Procedure	Erie	Utah	Alameda
Internal Medicine			
Complete history and physical examination			
	\$ 25	\$ 25	\$ 25
Routine follow-up office visit	5	5	5
Basal metabolism rate test	10	6	8
Electrocardiogram ¹	10-15	10-15	10
Neurology			
Neurological examination and report			
	25	15	15
Pediatrics			
Office visit ²	5	3-5	5-8

¹In Erie County, higher fee is for first tracing. In Utah, higher fee applies when done in home. ²In Utah, higher fee is for initial visit. In California, higher fee is for prolonged visit.

MORE ►

USUAL NONSURGICAL FEES (Cont.)

Procedure	Erie	Utah	Alameda
Hospital visit*	\$ 8	\$5-10	\$ 5
X-ray, Diagnostic			
Ankle	10	8	8
Chest, posteroanterior and lateral	15	15	12
Cholecystography	25	20	20
Encephalography	45	35	35
Pyelography, intravenous	30	25	25
Retrograde	20	20	25
Ribs	20	12	12
Upper gastrointestinal series	35	25	30
Ventriculography	30	35	35
Wrist	10	8	8
Radiotherapy			
Deep, per treatment visit	8	10	8
Superficial, per treatment visit	8	6	8
Pathological Examinations			
Blood count, complete	5	5	5
Urinalysis, complete, routine	2	2	5
Allergy Testing			
Scratch method, first 20 tests	25	—	15
First 18 tests	—	15	—

—*In Utah, higher fee is for first day.



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to neutralize,
not penalize

Usual Fees In Three Areas

[CONTINUED FROM 135]

know where they stand on fees. And the doctors' feeling is that this certainty outweighs all the disadvantages mentioned above.

What conclusions can we draw from their schedules of usual fees?

Here are some with implications for practicing physicians everywhere:

¶ Surgical fees vary considerably from one locale to another.

For example, the doctors in Erie County normally charge twice as much as their colleagues in Utah—and two and a half times as much as the California men—for the closed reduction of a tibia shaft fracture. For no more than a dozen comparable surgical procedures are the fees identical in all three areas.

¶ Startling variations show up in obstetrical and gynecological fees, too. In Utah, a miscarriage or abortion without surgery costs the patient three times as much as in Erie County. Yet the usual fee for dilation and curettage is



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SAFELY—no significant side effects reported.

INDICATIONS: For the "more normal" patient, in conditions where emotional stress is a factor, such as: tension • anxiety • neuroses • senile anxiety • insomnia • climacteric • peptic ulcer • functional G.I. spasm • hypertension • cardiac disease • anxiety, restlessness, night terror and hyperactivity in children.

DOSAGE: Adults, usually one 25 mg. tablet, or two teaspoonfuls Syrup, three times daily. Children (over 3 years), usually one 10 mg. tablet or one tsp. Syrup, once or twice daily.

Since response varies from patient to patient, dosage should be adjusted accordingly.

•••
—
SUPPLIED: Tablets: Tiny 10 mg. (orange) and 25 mg. (green), bottles of 100. Syrup: 10 mg. per teaspoonful, pint bottles.



BIBLIOGRAPHY: 1. Farah, Luis: Preliminary study on the use of hydroxyzine in psychosomatic affections. *Int'l. Rec. of Med. and G.P. Clin.* **16**:379-389 (June) 1956. 2. Robinson, Harry M., Jr., et al: Hydroxyzine (ATARAX) hydrochloride in dermatological therapy. *J.A.M.A.* **191**:604 (June 16) 1956. 3. Shalowitz, M.: Hydroxyzine: a new therapeutic agent for senile anxiety states. *Geriatrics* **11**:312 (July) 1956. 4. Noel, Guy: report by a neuro-psychiatric Department of the City Hospital of Giverny, Dept. of Health, 1955. 5. Lévy, G., Lévy, J., and Chvassan, J.P.: Initial results obtained with ATARAX in child psychiatry. Children's Neuro-psychiatric Service, LeSapetrière, Paris. 6. Bayart, J.: On treatment by hydroxyzine of nervous conditions during childhood. Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.



CHICAGO 11,
ILLINOIS

USUAL FEES IN THREE AREAS

the same in both places. California's ob./gyn. fees are, for the most part, surprisingly low.

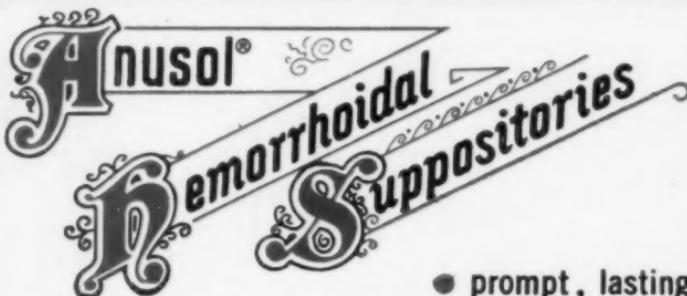
¶ Urological fees are generally highest in the two California counties. A nephrectomy, for instance, costs the patient \$75 to \$100 *more* in Alameda-Contra Costa than in the other two areas; and a prostatectomy costs twice as much. The same pattern applies to pathology and ENT work.

¶ Procedures in the fields of internal medicine and pediatrics command roughly the same fees in all three locales.

¶ Utah has the lowest consum-

er purchasing power of the three areas—and the highest single fee for any comparable procedure: \$600 for a total gastrectomy or a complete proctectomy with abdomino-perineal resection. The fee for these two procedures is \$100 lower in Alameda-Contra Costa, \$250 lower in Erie. Yet both the latter areas are richer in per capita buying power.

¶ Usual fees in the area studied here are generally higher than local Blue Shield indemnities—about 10 per cent higher in Erie County, and about 50 per cent higher in Utah. END



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In Asthma

For Rapid Relief of Acute or Continuing Bronchospasm

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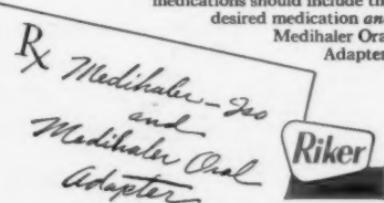
Riker brand of epinephrine 0.5% solution in inert, nontoxic aerosol vehicle. Each ejection delivers 0.125 mg. epinephrine. In 10 cc. vial with metered-dose valve, sufficient for 200 inhalations.

Medihaler-Epi replaces injected epinephrine in emergency situations in which respirations have not ceased. It provides rapid relief in acute food, drug, or pollen reactions (including urticaria, bronchospasm, angioneurotic edema, edema of glottis, etc.). In most instances only one inhalation is necessary.

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'Toughest Kind Of Practice Today!'

Straight from the shoulder, right from the heart, here it is: an account of the G.P.'s woes, as only the rural man knows them

By Jacques Grunblatt, M.D.

"Write up your ideas," you say in your announcement of the 1956 MEDICAL ECONOMICS Awards.

How can I? Before I'm even able to think, I'm awakened out of my early-morning dreams by the rough ring of the bedside phone. A voice says:

"Doctor, before I leave for work I wanted to tell you to come see my mother. She isn't well."

"All right," I answer. "I'll be over." Even if I can remain in bed, I have to concentrate so as not to forget the name and the call.

Before I'm shaved, showered, and dressed, there are more calls. Some pull me out all wet from the shower to answer questions on the phone. By the time I'm down for breakfast, I've already got several problems on my hands and in my head.

Breakfast isn't ready. My wife in her tender, loving manner wants me to have nice, crisp, warm bacon. So she

"TOUGHEST KIND OF PRACTICE TODAY"

has waited for me. Now I have to wait, and I blow my top. "Can't you synchronize your actions with my work?" I say too loudly. My day has started.

Office at Home

In the office—which means in the next room—the nurse is boiling the syringes. But even before they've boiled, the doorbell rings. It's a couple of early callers—some sort of pseudo-emergency. I have to take care of them. While I'm seeing them, the doorbell rings again.

I'm thinking of the home calls

I promised for the morning. Will I be able to keep my promises? Maybe. I work. The doorbell rings again.

Meanwhile, the nurse answers the telephone and accumulates more problems for me. From time to time I call her away from her paper work to help me weigh a baby, take a temperature, or apply a dressing. She's unhappy. She wants to finish some papers and get them in the mail.

As a matter of fact, she wants some signatures from me, and some answers. Is So-and-So able to work? How long will his treat-

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before bedtime.

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"TOUGHEST KIND OF PRACTICE TODAY"

ment last? (She has workmen's compensation forms to fill out.)

There are also some letters to answer, some welfare papers to make out (deadline forty-eight hours from now), insurance forms, and such.

And so it goes until late at night.

In this hustle and bustle, you don't have time to worry about your problems. But this you know: The problems of a general practitioner in a small rural community more than thirty miles

from the nearest hospital are many and pressing.

First, there's economics. The country G.P.'s ratio of uncollectable and uncollectible bills is the highest. As a result, if you consider the hours he works, he's no better paid than a plumber—may be worse. And he's certainly not favored by insurance companies or county welfare agencies. Let me cite a couple of examples:

There's an old man who likes to live alone on a back road. Late one stormy winter night, his neigh-



**"Believe me, Miss Hollaway, there's absolutely
nothing wrong with you."**

“...an ideal treatment for the diarrheal syndrome...”¹

RESION

(POLYAMINE METHYLENE RESIN AND SYNTHETIC SILICATES)

faster relief²

In 90 patients treated with Resion, 86 (95%) were controlled in 8 to 12 hours, faster than even with bismuth and paregoric.

twice as effective²

THERAPY	% SUCCESSES
RESION	92
Kaolin and Pectin	40
Bismuth and Paregoric	50

safe³...and non-constipating¹⁻³

The multiple adsorbent and ion-exchange materials in Resion are “totally insoluble and non-toxic.”³ No cases of constipation reported in three clinical series of more than 250 patients.¹⁻³

Available IN 2 PLEASANT-TASTING DOSAGE FORMS

Resion—for simple diarrhea Polyamine methylene resin 10%; Sodium aluminum silicate (synthetic) 10%; Magnesium aluminum silicate (synthetic) 1.25%.

Resion P-M-S—for infectious diarrhea Resion; Polymyxin-B 125,000 units; Phthalylsulfacetamide 1.0 Gm.; Methyl Paraben 1.33%; Propyl Paraben 0.33%; Butyl Paraben 0.1%; in each tablespoonful (15 ml.)

Dosage: RESION..... 1 tablespoonful hourly for 4 doses; then every three hours while awake.

RESION P-M-S. 1 tablespoonful hourly for 3 doses; then 3 times daily. Infants—the same schedule as above, but in teaspoonful doses.

Supplied: Resion is supplied in bottles of 4 and 12 fluid ounces;
Resion P-M-S in bottles of 4 fluid ounces.

REFERENCES: 1. Weiss, J.: K.A.G.P. Journal 2:33, 1956. 2. Gabroy, H. K., and Selaman, G. J. V.: Amer. J. Dig. Dis. 20:305, 1953. 3. Lichtman, A. I.: Exper. Med. & Surg. 9:90, 1951.

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Philadelphia 44, Pa.

R-2700/57

"TOUGHEST KIND OF PRACTICE TODAY"

bors find him critically ill with pneumonia. He's cyanotic, almost in coma.

The first person they call, naturally, is the doctor. So I drive out seventeen miles on a slippery and only half plowed road.

I give the old fellow some emergency treatment and send him to the hospital as a welfare case, pending investigation. By the time the ambulance arrives and I have the man on his way to the hospital, it's dawn.

The patient is accepted as a welfare case. But when I send my bill to the welfare agency, it

comes back with this note: "Case not active at time of admission." Next time something similar happens, should I call the commissioner of public welfare? Should I insist that he send his case worker to see whether the case becomes "active" before I devote most of a night to it?

Cheating the Doctor

Here's another example—about one of those families that make a hobby out of cheating the doctor by not paying his bills. We all have such cases. The husband works; he even has hospi-

specific enzyme test for urine-glucose

QUICK

Yes or **No**

**for daily check by mild and
well-controlled diabetics**

packets of 30 CLINISTIX Reagent Strips in protective foil pouch

bottles of 60 CLINISTIX Reagent Strips for economy, convenience in office testing

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Reagent Strips



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integrated relief . . .
mild sedation
visceral spasmolysis
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TABLETS (yellow, coated),
each containing 50 mg.
Trasentine® hydrochloride
(adiphenine hydrochloride CIBA)
and 20 mg. phenobarbital.



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'TOUGHEST PRACTICE'

talization; but he successfully avoids paying his family's doctor bills.

One Sunday afternoon, when just such a man brings in his wife with an attack of acute cholecystitis, I have to treat her and arrange for her admission to the hospital. She's operated on. She develops a bile fistula, and I have to change dressings for weeks. Eventually the hospital is paid; the surgeon is paid; and I become the victim of her husband's hobby.

Next time, maybe I should ask the surgeon to keep the case a few weeks longer in the hospital, and see how the insurance company likes it.

There just aren't enough provisions in the welfare laws and in insurance policies to protect the forgotten man: the country G.P. And what provisions there are aren't good enough.

You Can't Get Away

When you start out in rural practice, you overlook the problems. But as time goes on, you get tired. In a crisis you may even think of dropping it all and running away. But then you remember your many loyal patients. You look at the breathtaking beauty of the countryside. And you realize it isn't easy to leave. [MORE ▶]



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Overeating is a bad habit—
you can help your patients
to break it

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Available as tablets, elixir, and Spansule[†]
sustained release capsules.



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'TOUGHEST PRACTICE'

Once every ten years, though, the country doctor should have a chance to go away for six months or a year. He should spend this period in a hospital or some similar institution. He should see different ways of practicing. What the rural man needs is more chance to mingle on a scientific basis with other doctors.

I hesitate to mention income taxes as one of the special problems of the doctor in a small village. But taxes are especially rough on him. Sometimes I even dare to doubt the wisdom of the income-tax laws. A doctor isn't a factory owner who can increase his income by adding another wing to his factory and hiring more help.

Overtime Worth Less

In some respects, we're worse off than the average factory worker. When the worker works overtime or on holidays, he gets paid time and a half or even double time.

But when the doctor drags himself out of bed to make a night call, or interrupts his Sunday dinner to see a patient, he only gets himself into a higher income-tax bracket—which makes his overtime work worth less.

I'm reminded of the Mexican income-tax collector who was in-

when he smokes
the greatest
pains self-induced
and accompanied with
GELUSIL®
the most
soothing and
relaxing anesthetic
in the world

extra protection
for every conception

Hesper-C Prenatal

with capillary-protective factors

a precaution in normal pregnancy
a necessity in habitual abortion^{1,2}

The problem of spontaneous abortion is not limited to habitual aborters. It is estimated that 10% to 20% of all pregnancies end in spontaneous abortion. Studies by Greenblatt,^{1,3} Javert^{4,5} and Dill² have revealed that integrity of the decidual vessels is a key to successful completion of pregnancy... and confirm that hesperidin complex and ascorbic acid, provided by Hesper-C Prenatal, restore and maintain capillary integrity.^{6,7}

In several groups of habitual aborters, these researchers effected substantial fetal salvage—as high as 95% in one series⁴—when Hesper-C (hesperidin complex and ascorbic acid) was added to a regimen of prenatal supplementation and therapy.

Only Hesper-C Prenatal gives your patients the extra protection of hesperidin complex and ascorbic acid, plus established prenatal vitamin-mineral supplementation, at a nominal increase in daily cost.

Hesper-C Prenatal is the only *complete* supplement for *all* your pregnant patients.

Each capsule contains:

Hesperidin Complex	100 mg.	Folic Acid	0.05 mg.
Ascorbic Acid	100 mg.	Pyridoxine Hydrochloride	1.67 mg.
Vitamin A Acetate	1000 U.S.P. units	Calcium Pantothenate	1.0 mg.
Vitamin D ₃	200 U.S.P. units	Ferrous Gluconate (2.5 mg. iron)	21.6 mg.
Thiamine Mononitrate	1.25 mg.	Calcium Carbonate (83.3 mg.	
Riboflavin	0.75 mg.	calcium)	208.25 mg.
Nicotinamide	5.0 mg.	Copper Sulfate (0.5 mg. copper)	2.0 mg.
Vitamin B ₁₂	0.75 micrograms	Potassium Iodide (0.05 mg. iodine)	0.065 mg.

In bottles of 100 and 500 capsules.

Recommended daily dose: Two capsules t.i.d.

Providing the daily requirements or more of vitamins and iron during pregnancy as recommended by the National Research Council.

References: 1. Greenblatt, R. B.: Obst. & Gynec. 2:530, 1953. 2. Dill, L. V.: M. Ann. District of Columbia 23:667, 1954. 3. Greenblatt, R. B.: Ann. New York Acad. Sc. 61:713, 1955. 4. Javert, C. T.: Obst. & Gynec. 3:420, 1954. 5. Javert, C. T.: Ann. New York Acad. Sc. 61:700, 1955. 6. Barishaw, S. B.: Exp. Med. & Surg. 7:358, 1949. 7. Selzman, G. J. V., and Horoschak, S.: Am. J. Digest. Dis. 17:92, 1950.

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"TOUGHEST KIND OF PRACTICE TODAY"

specting the books of a storekeeper and was surprised to see that the man made exactly ten pesos every day.

"Pedro, how come you make exactly ten pesos a day?" the inspector asked.

"It's easy," the storekeeper answered. "When I've made my ten pesos, I close the store."

We rural physicians can't close

our doors. We can't even take the telephone off the hook. We can't do anything except keep going.

Note that I'm speaking for the man who's *really* a country doctor, the one who's thirty miles or more from the nearest hospital. I know we're in a minority. Even so, out of a total of seventy physicians in my county, at least ten are in this predicament. Projected



blue at breakfast?

BONADOXIN[®]

(brand of meclizine dihydrochloride and pyridoxine hydrochloride)
stops morning sickness

manifest in 3 out of every 4 pregnancies. Relief with BONADOXIN was over 90% in controlled studies, which termed results "good to excellent."^{1,2,3,4} . . . tolerance "excellent."¹ Complete relief is often afforded "within a few hours."²

Each BONADOXIN tablet contains:

Meclizine HCl 25 mg.
Pyridoxine HCl 50 mg.

In mild cases, one BONADOXIN tablet at bedtime. Severe cases, one tablet at bedtime and on arising.

Supplied: Tiny pink and blue tablets, bottles of 25 and 100 . . . prescription only.



... and as pre-natal supplementation,

STORCAVIT[®]

the new, phosphate-free formula, which brings the gravida vitamin-mineral supplementation and full-term freedom from leg cramps.[†] Rx: one tablet t.i.d.—p.c.

STORCAVIT[®] (comprehensive formula of vitamins A, B complex, C, D, E and of minerals, phosphate-free)

Supplied: Orange-colored, tablets, bottles of 100.

† when due to high phosphorus intake

PEACE of mind ATARAX[®]



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REFERENCES: 1. Weinberg, A. and Werner, W.E.F.: Am. Pract. & Dig. Treat. 6:580, 1955. 2. Grosklos, H.H. et al: Clin. Med. 2:885, 1955. 3. Crawley, C. R.: West. J. Surg. Gynec. and Obst. 8:463 (Aug.) 1956. 4. Tartikoff, G.: Clin. Med. 3:223 (Mar.) 1965.

'TOUGHEST KIND OF PRACTICE TODAY'

on a nation-wide scale, that makes an impressive number.

We in the country know there's more to life than just making a living. We know there's a wide world of fine arts, literature, music, and philosophy. But it takes leisure time to cultivate such pursuits. And time is more than money for the busy rural practitioner. It's something he simply can't get.

His only contact with the world is through his patients. So it's from them that he must get not only his economic but also his in-

tellectual subsistence. And, believe me, his rural patients are sometimes a pretty meager source of spiritual nourishment.

Whose Fault?

What's the moral of all I've been saying? The only moral I see is this: When you meet a village doctor whose manner is brusque and whose conversation is dull, understand that it's not all his fault.

There are probably some other things I ought to have said in this article. But I just haven't the time to figure them out. END

Staff Meeting Tonight

The world has so much in the way of disease,
I'm sure we have all been as busy as bees.
I know at the end of a frustrating day
I'm thinking of home and of hitting the hay.

Re a meeting tonight: A discouraging fact is
It won't be improving my mind or my practice.
A meeting's a must till I've filled out my quota;
But this is the night for a bourbon and soda.

And this is the night, though I ought to be thinner,
For stuffing myself on a leisurely dinner.
So carry on, men, and I hope you do well with it.
Tonight is one night I'll be saying the hell with it!

—ERIC R. SANDERSON, M.D.

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END

the plus value...
increased improvement
+
fewer electrolytic
side effects

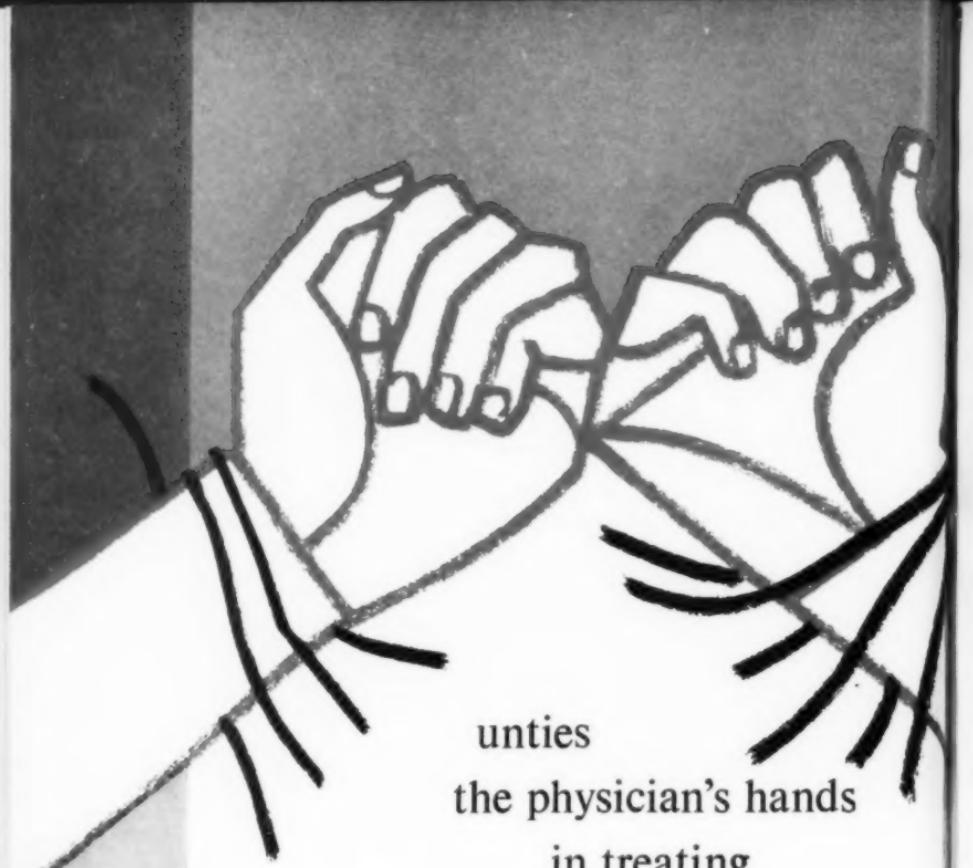
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TABLETS

prednisolone

- benefits patients longer because discontinuance due to fluid retention or hypertension is rarely necessary.
- edema, electrolyte disturbance, and associated blood pressure elevation are virtually nonexistent in average dosage.
- valuable in a wide variety of disorders amenable to corticosteroids including—drug reactions, atopic eczemas and rheumatic fever as well as rheumatoid arthritis and asthma.

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the physician's hands
in treating
the asthmatic

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rapidly relieves dyspnea • increases vital capacity
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...usually without edema due to salt retention

METICORTELONE — 1, 2.5 and 5 mg. buff-colored tablets.

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YOU PRAISED ITS RICH, FULL FLAVOR *... your patients will do the same!*

"Delicious! Full-bodied!" That's how you described Instant Sanka Coffee when you tasted it at medical conventions.

Your patients will be grateful when you tell them about Instant Sanka. If they're sensitive to caffeine, they can still drink all the coffee they want by

switching to Instant Sanka, because it's pure coffee with the caffeine taken out.



All pure coffee . . . 97% caffeine-free

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Decisions They Want You to Make

A patient doesn't always put these questions directly to you—but they're likely to be on his mind. Here's how to handle them

By John E. Eichenlaub, M.D.

Want to play God?

Most of us don't. But patients frequently present us with their problems, submit their bodies to our ministrations, and then await word from on high. They want us to tell them **WHAT TO DO**. They want us to spare them from having to make difficult decisions.

The following twelve questions seem particularly to plague patients unless the doctor answers them specifically in his original instructions:

1. *"What can I do and what must I avoid doing?"*
Many patients seem to want detailed guidance on activity and rest. Especially when they're severely ill, such patients often associate physical exertion with instant death. One of my cardiacs put it this way:

"I'm just plain scared to move, Doctor."

"Why?" I asked.

"I've heard about so many heart cases. Like the time

Jim Moore ran to catch a bus and dropped in his tracks, stone dead. That's not for me. I want you to tell me exactly how much it's safe for me to do."

When a man talks that way, there's no doubt about it: He needs firm advice on his activities—if for no other reason than to control his fears. Even if he doesn't mention such fears, they are probably there.

2. "*Should I stay in bed?*" Whether to sit up or lie down, whether to use pillows, whether to raise the head or foot of the bed—patients are often uncertain about these things. One of my colleagues got me into the habit of not merely explaining such matters, but of *demonstrating* them. For instance, I'll show the patient how to sleep with his hand on a pillow on top of his chest at night.

3. "*What can I eat?*" I've learned that even a few changes in a standard diet make the patient feel he's getting more truly personal help.

"Go according to this list," I tell him, digging into my file of diets. "You'll notice that the sheet says no very hot or cold foods. But you can take ice cream if you eat it slowly and let each bite melt in your mouth. And let your coffee or soup cool to just above room temperature before you take it."

Weight-reduction patients need more talking-to. "You can't make a separate decision over every salted peanut," I often say to such patients. "Make one big decision only: to follow the program I prescribe. I'll make it so specific



ECZEMA

Coal Tar Therapy without its many disadvantages

All the therapeutic advantages of coal tar for eczema and similar dermatoses are retained in SUPERTAH (Nason's) without black coal tar's odor and repulsive appearance.

SUPERTAH (Nason's), a white creamy ointment of crude coal tar, has these advantages:

Does not burn or irritate the skin*. Does not stain linen, clothing or skin. Does not have to be removed before each fresh application.

DOES everything crude coal tar ointment will do.

*Swartz & Reilly, "Diagnosis and Treatment of Skin Diseases," page 66

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SUPERTAH (NASON'S)

At leading prescription druggists
2-oz. jars. (5% & 10% strength)

ABOVE CASE AFTER
3 WEEKS TREAT-
MENT USING
SUPERTAH
(NASON'S)
OINTMENT



DECISIONS TO MAKE

that you'll know exactly what to do. And as long as you keep your diet sheet with you, right there at the table, you'll be able to beat temptation without thinking twice about it."

4. *"What, and how much of it, should I drink?"* If we want the patient to force fluids, he's most likely to do it if he gets directions as specific as these:

"Take a small juice glassful every fifteen minutes when you're awake. Keep what you're going to drink in a one-quart milk bottle. And be sure you empty the bottle at least three times each day."

Some doctors make up a specific list of approved fruit juices and caffeine-free carbonated drinks. And they tell their patients whether or not to take juice



restores vitality

THERACEBRIN

(Pan-Vitamins, Therapeutic, Lilly)

for a really vigorous multiple-vitamin regimen



In bottles of
30, 100, and 500

DISTINGUISHED MEMBER OF THE *Lilly* FAMILY OF VITAMINS

DECISIONS THEY WANT YOU TO MAKE

while medicine is in their stomachs.

5. *"Do I need anything for my bowels?"* It's a rare patient who doesn't wonder what to do if his bowels stop up. Whenever I forget to discuss this matter, I'm not surprised if an apologetic voice soon comes through the phone: "I hate to bother you, Doctor, but I've been wondering . . ."

In many cases I find it best to take total responsibility for bowel control. I do it by issuing an order like this: "If you haven't had a movement by Thursday

evening at 6, take a salt and soda enema." Or "If you go three days without a movement, take a dose of magnesia."

6. *"Do I need to tell you anything or to bring you anything next time?"* It's easy—if you think of it—to tell your patients when to take their temperature or what specimens to bring in.

Diuretic Prediction

A doctor-friend of mine says he goes even further with the younger set: Since an impending visit to the doctor's office seems to be a universally effective child-

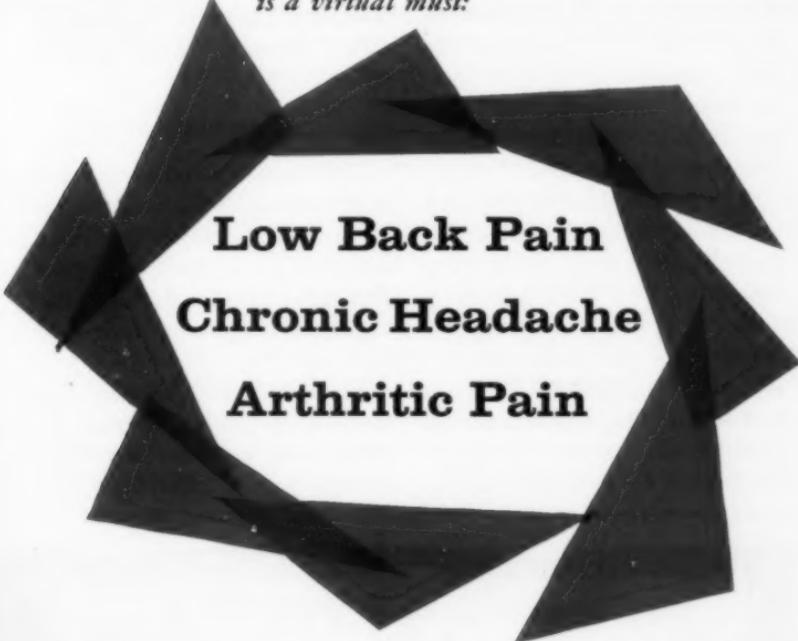


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Aspergum gives immediate
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increases saturation and
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A welcome medication to
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especially after
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where the
"KEY TO HIGHER ANALGESIC POTENCY"
is a virtual must:



Low Back Pain
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Short of resorting to the narcotics, the key to higher analgesic potency is elevation of mood.

'Daprisal', because it contains the mood-ameliorating components of 'Dexamyl', relieves the depression, nervous tension and anxiety which nearly always accompany persistent pain—and which combine to intensify it.

Try 'Daprisal' tablets in your next case of moderately severe chronic pain. You will be pleased with the results . . . and so will your patient.

DAPRISAL*
a combination of aspirin, phenacetin and the
Mood-Ameliorating Components of Dexamyl*

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DECISIONS THEY WANT YOU TO MAKE

hood diuretic, he often tells fond mothers that shortly before they leave home Junior will head for the bathroom.

"Hand him a bottle then," says my friend. "And be sure he knows what to use it for."

The doctor gets his specimen—plus the extra confidence that patients grant only to the clairvoyant.

7. *"Can I take anything for discomfort?"* Some patients are alternately agonized by symptom-seeking introspection and by guilt if they resort to relief. "What am I," one man said to

me recently, "a sissy or a neurotic, that I keep taking pain pills every time something goes wrong?"

Rx Instructions

For such persons—and for others as well—the understanding physician prescribes relief measures very precisely. Then patients feel the decision has been his, not theirs, each time they reach for a pill.

In most acute illnesses, I've found it's possible to predict patients' need for relief accurately enough to order anodynes by the

for Nausea and Vomiting

ALWAYS

EMETROL[®]

(Phosphated Carbohydrate Solution)

Highly effective when condition is functional; will not mask organic derangement; safe physiologic action . . . no drug side effects.

proved in: *epidemic vomiting, functional nausea—children, 1 or 2 tsp.; adults, 1 or 2 tbsp.; repeat every 15 minutes until vomiting ceases.*

proved in: *"morning sickness" — 1 or 2 tbsp. on arising; repeat in three hours and whenever nausea threatens.*

In bottles of 3 fl.oz. and 16 fl.oz. DO NOT DILUTE

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COLUMBUS, INDIANA

day instead of by the dose. Another doctor in my locale prefers to give instructions like these:

"Take two tablets four times a day until the day after your temperature has been normal at every reading. Then take one tablet four times a day until your recovery is complete, or until you come to see me."

Threshold of Pain

Sometimes it's even possible to gear your instructions to the individual's pain threshold. A former professional boxer whom I once treated for flu had such a

high threshold to discomfort that I told him: "Take this pill at the slightest ache or twinge."

On the other hand, a babyish woman who said she'd been "about to vomit for three days" was given these seemingly over-conservative instructions: "When you're sure you can't keep from vomiting a minute longer, take a pill and lie down with a cold cloth on your head. But wait until the last possible second, in order to get the full effect."

8. *"Will I need to get my prescription refilled?"* Patients often assume that the prescribed quan-

CLINICAL REPORT:

gas, bloating, heartburn
seemed to "melt away"
as soon as they swallowed

Coactyn®

new systemic antispasmodic with a pH-adjusted vehicle
for immediate topical relief to the spastic gut

Each tsp. contains 0.5 mg. homatropine methylbromide and 8 mg.
phenobarbital in pH-adjusted phosphorated carbohydrate solution.
Dose: 1 or 2 tsp., undiluted; particularly effective on empty stomach,
15 minutes before meals. In bottles of 3 fl.oz. and 16 fl.oz.

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Please send me "Letters to a Doctor's Secretary." I enclose \$2.

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DECISIONS TO MAKE

tity of medicine is par for the course. They apparently feel you've failed if that one round doesn't do the trick.

A good way to stave off this problem is to say: "We'll give you a starter quantity of this medicine. Then, if we have to switch to another remedy, you won't waste a lot of money. But if it works out for you, you'll probably have to get more of it at the drugstore."

9. *"How long do I need to keep on taking my medicine after I feel better?"* We've all seen patients who believe that each dose of medicine works on a certain symptom—and works immediately or not at all. Ask Grandpa about his heart, and he says: "Feel fine as long as I take my medicine." But one day soon, he may forget a dose or two and find out he doesn't get short of breath after all. So the next time his prescription needs a refill, he may not bother. Not until you scrape him up in heart failure again.

One way to meet this problem is to talk turkey to patients with heart conditions, pernicious anemia, diabetes, and the like:

"The hardest thing in this kind of illness is to decide when to cut down your program. Your medicine blanks out the symptoms that make it easy to decide. So



She stays healthier when she stays trim

ALTEPOSE

Putting on weight—even a few pounds—can be a danger signal. But weight control as well as weight reduction requires your patient's cooperation. ALTEPOSE can help you, for it makes reducing easier. ALTEPOSE contains 'Propadrine' to curb appetite, thyroid to release tissue-bound water, and 'Delvinal' to relieve irritability.



MERCK SHARP & DOHME

DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

DECISIONS THEY WANT YOU TO MAKE

come in for some scientific tests if you think you're due for an easing up of the program. We'll check you to see if you're ready. But don't do anything on your own."

10. *"Would heat or cold help?"* In other words, what home types of physical therapy might give either symptomatic or therapeutic relief? Even if the patient doesn't actually take the treatments, he's usually grateful for knowledge of "what to do if my bum joints get bad enough to be worth the trouble."

11. *"Might I need to come*

back or call before my next appointment?" There are patients who are shy about "bothering" the doctor. So I find it best to explain exactly what symptoms or signs should make the patient call me in advance of his next appointment. I learned the need for such instructions as the result of an experience with one of my very first private patients:

He was a 12-year-old boy who'd cut his foot on a bottle. I sewed him up, put on a bandage, and told him to come back in five days to get the stitches out. Five days later, when his parents

the first gamma globulin specific for mumps



Passive prevention or treatment of mumps in children and adults. In treatment, reduces incidence of orchitis markedly if administered early in adequate amount.

ANTIMUMPS SERUM (Human), concentrated

The gamma globulin fraction of blood from healthy human donors who have been hyperimmunized with mumps virus vaccine.

2.5 cc. vials

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Other Hyland gamma globulin concentrates: **Antipertussis Serum (Human)**, Concentrated—2.5 cc. **Poliomyelitis Immune Globulin (Human)**—2 cc. and 10 cc.

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When the "will to lose" wears thin . . .

you can prescribe **BIPHETAMINE** and count on

PRE-DETERMINED APPETITE CURBING due to 'Strasionic'—sustained

ionic—release. "... 90% of the patients reported satisfactory or excellent effects (curbing of appetite for 10 to 14 hours)."

PATIENT APPRECIATION. "High enthusiasm (observed by) investigators . . . In addition to the excellent effect of the **BIPHETAMINE**, this single dosage form was more convenient."

PREDICTABLE WEIGHT LOSS.

Freed and others^{1,2,3} report dependable appetite suppression and striking weight loss with one Biphetamine capsule daily.

Rx Biphetamine 12 1/2 mg. or Biphetamine 20 mg. capsules containing a mixture of equal parts of amphetamine and dextro amphetamine in the form of a resin complex.

REFERENCES:

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3. Freed, S. Charles and Mizel, M.—*Annals of Internal Medicine* 36, 1492 (1952)

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brought him in, he was a trembling, feverish, unable to put his swollen foot on the ground.

"How long has he been this way?" I asked. The thermometer showed 104°; the leg looked badly infected.

"Four days," his father muttered. Then, feeling my disapproval, he flared out: "I wanted to bring him in, but you said five days. We figured you knew what you were about."

I've never since let a patient get out of my office without extra instruction. If possible, I tell him exactly what complications

should bring him in. Or else I outline the expected course of his illness and then say, "If things don't go along at least as well as I've led you to expect, call me up right away."

12. *"When should I come back, if at all?"* As long as the patient isn't entirely sure he's well, he wants his doctor to stay close to the case. He wants to be told to report back—and he wants to know exactly *when* to do so. To his mind, there's one single moment at which stitches are just ripe for plucking or pneumonia deserves a new X-ray. [MORE ▶]

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A MESSAGE TO THE PHYSICIAN
FROM
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THE PRICELESS PRESCRIPTION

We did a little browsing the other day in the figures of the U. S. Department of Labor's Bureau of Labor Statistics, and this is what we found:

Clothing costs were 104 per cent higher than the 1934-39 average, house furnishings were 112.15 per cent higher, and recreation 68.3 per cent higher. Medical costs were up only 64.7 per cent.

One observer estimates that the 845,000 men and women kept alive during the last eight years through the skill of the physician and use of the newer drugs have contributed almost a billion and a half dollars to the national income and 230 millions in taxes to the U. S. Treasury.

And according to one recent annual report of the Department of Commerce, per capita expenditures for drugs was \$10.12, as compared to \$55 for alcoholic beverages, \$32 for tobacco products, and \$18 for the repair, maintenance and parking of automobiles.

Out of the \$10.12 drug bill, \$6.43 went for prescriptions.



But to weigh the cost of a drink against the cost of a drug is to compare things which just can't be compared.

What are the human values with which we *should* equate the dollar cost of a prescription?

It's the young mother who has just had a baby, and already owes a debt of lasting gratitude to a man she's never heard of and will never see. He's a research scientist in a distant laboratory, supported in part by a tithe from the cost of the intravenous anaesthetic the new mother received in the delivery room. And presently the scientist is going to isolate a hormone or virus which someday may save her baby's life.

* * *

Viewed in such terms, talk about the "high cost of drugs" loses its relation to any measurable yardstick. No price is too high nor too low. Such drugs are, quite literally, priceless. Just as life itself is priceless.

But quite apart from this value scale, and viewed simply as "consumer goods", prescription drugs are not in fact out of line with the yardstick for other things we buy.

For two decades the percentage of disposable income spent for medical care, including drugs, has varied only slightly from a consistent four per cent. The authority is the U. S. Department of Commerce.

Again, from the Journal of the American Medical Association:

"A further indication that prescription prices are not,

on the whole, out of line, is that the price index for prescriptions in 1954 was 115.8 as compared with an index of 114.8 for all consumer goods and services."

And drug costs were lower than the 1.25 index embracing the sub-indexes which make up the cost of all medical care.

Quoting an audit of 200,000 prescriptions filled in 200 drug stores from coast to coast, the J.A.M.A. reports an average prescription price of \$2.51. Another survey, conducted by a team from the Brooklyn College of Pharmacy, placed the average cost even lower, at \$2.36, with one-half costing \$1.41 or less, and only six per cent more than \$5.00. The Medimetric Institute, Inc., says the current average price is \$2.27.

* * *

The price of insulin is six percent of what it was thirty years ago, and the diabetic who used to face a two-to-one chance of an early death in diabetic coma now lives out his normal expectancy on a drug whose daily cost is little more than half the price of a package of cigarettes.

For five cents a day, an epileptic who was once a burden to himself and to his family can now be a productive, self-supporting citizen.

Part of the price of a prescription helps pay for the research which discovered and developed the drug, and for the continuing search for new ones. And properly so.

As someone has said, the price of a prescription is "the American way of apportioning the cost of research among those who benefit the most from it."

What does this mean, in terms of human experience?

It's the adult American who remembers some relative or friend whose death certificate read "tuberculosis" — and the extra pang of regret he feels that the loved one didn't live to know the efficacy of a drug like isoniazid.

* * *

Other members of the medical team are also targets of the "high cost" resentment. An N. O. R. C. survey for

Health Information Foundation showed that 69 per cent of the people think hospital charges are too high, 55 per cent complained about the size of their dental bills, and 49 per cent were holding an "over charge" grudge against their doctors.

A leader in the drug industry summed it up this way:

"Most people feel they get their money's worth when they are out ten to twenty dollars for an evening's entertainment, but resent it when it costs them the same amount for the services of a physician whose skill may determine whether they live or die.

"The cost of two weeks' vacation is ordinarily regarded as reasonable, but when the same amount goes to pay a hospital bill it is considered robbery. Visit the poor districts in your city, where live the so-called medically indigent, and you will find the roofs bristling with television antennas.

"The very survival of free enterprise in medical care and in the drug industry may hinge on whether or not the public thinks it is getting its money's worth."

* * *

People—because they're people—will probably go right ahead paying cheerfully for their momentary pleasures while griping about the cost of permanent relief from pain.

But the physician, with a quiet recital of the facts, can relieve them of this burden of complaint while addressing himself with all his current skills to a correction of their ailments.

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He won't be taught otherwise, I've found, by being given a vague return date. He'll simply be convinced that the doctor doesn't know his stuff.

Limit Your Controls

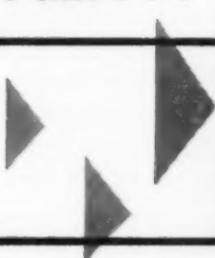
Do you make all the decisions your patients want from you? Do you instruct them explicitly, so that they know exactly what to do and when? If so, you've learned that patients respond well to such control if you use it sensibly.

Most doctors don't force their decisions on the patient in any

major issue, or when a long-range change in living habits may be called for. They merely explain the reasons for their firm instructions; and the reasons themselves are usually all the co-operative layman needs to make him comply.

Whenever you thus relieve a patient of having to make unwanted decisions, he's likely to be grateful for your support. And you're likely to get some extra satisfaction, too: the satisfaction that comes from complete patient management, which adds pleasure even to routine. END

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Disciplinary Board Begins Policing Doctors

One state's doctors have undertaken a unique experiment in self-policing. It may well serve as a precedent for similar tests elsewhere

By Hugh C. Sherwood and Harold F. Osborne

Can doctors police themselves—and make the punishment fit the crime? That's a burning question these days in Washington State medical circles.

About two years ago, the state government empowered Washington physicians to set up a medical disciplinary board with legal teeth—with authority, in other words, to penalize medical men guilty of unprofessional conduct.

The board differs notably from typical grievance committees in two respects: (1) Its members are elected by their colleagues in the state rather than appointed by the medical society; and (2) its decisions have full legal backing.

The board also differs notably from typical state boards of medical examiners. It has jurisdiction over a wide range of offenses not usually handled by examining boards. And it has been granted a state appropriation in order to make active investigations of such offenses.

Thus the six doctors who now constitute the disciplinary board have a legislative mandate to clean house. Trouble is, their first efforts to wield a broom have stirred up a hornet's nest. It's wrapped around the following highly debatable questions:

What, precisely, is the meaning of "unprofessional conduct"? Does it include tax evasion, for instance?

These questions rise out of the board's first major decisions. Last fall, it suspended the licenses of two Washington doctors who'd been convicted of—and fined and jailed for—evading Federal income taxes.

One of the two men is still in prison. The other appealed his suspension to the state's courts. And although his first appeal has been denied, many of his colleagues believe him thoroughly justified in resenting the ruling.

On the other hand, some Washington physicians maintain that the board was too lenient in its treatment of the convicted men. So the state's doctors are far from unanimous in evaluating their unique experiment in medical self-policing. When and if medical opinion does crystallize, it may determine whether similar disciplinary boards will be set up in other parts of the country.

Before examining the doctors' current reactions, let's look at the Medical Disciplinary Board itself. It was conceived by the Washington State Medical Association. Not a medical voice was raised against the idea when it was discussed in the State Legislature. And once the board became a legal entity, some 70 per cent of Washington



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*1. Bickerman, H. A. and Barach, A. L.: Am. J.
Med. Sc. 228:156, 1954.*



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DISCIPLINARY BOARD

doctors took part in the election of its members.

The board filled a sizable gap in the state's medical picture. Until its creation, only the lay-operated State License Department had the power to revoke doctors' licenses. And it had rarely used its power.

"Once a license was revoked, it could not be reinstated," explains Dr. M. Shelby Jared, past president of the state medical society. "Naturally, revocation was rarely resorted to. That left us with no way to discipline doctors who were guilty of minor offenses. So we pressed for creation of the board."

What the Law Says

Under the medical disciplinary act, a doctor may be tried by the board on charges of unprofessional conduct, brought by "any person, firm, corporation, or public officer." What's more, the board itself may initiate proceedings, even if it hasn't received a formal complaint.

"Unprofessional conduct" is elaborately—but not completely—defined by Washington state law. A doctor, it says, may be considered guilty of such conduct if he's convicted of any of the following offenses, among others:

Criminal abortion, fraud in

obtaining a license, willful betrayal of a professional secret, willfully false testimony in a malpractice suit, aiding an unlicensed person to practice medicine, rebating, habitual intemperance, misuse of narcotics—and moral turpitude.

This last crime, it has since become clear, may cover a vast multitude of misdeeds.

He Can Appeal

The rights of an accused doctor are well protected under the law. When he appears before the board, he can bring along as many lawyers as he wants. If he's found innocent, the board will help clear his name. If his offense is minor, he may merely be reprimanded. If his license is suspended, he's assured of eventual reinstatement. And if he feels the board has acted unjustly, he can appeal its ruling all the way up to the State Supreme Court.

Petty Grievances

As you might guess, a great many complaints—small fee disputes and the like—are still being handled by medical society grievance committees at the county level. Such committees, however, have no direct connection with the disciplinary board, which is an agency of the state. [MORE ▶]



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1. Konzett, H.: *Wein. klin. Wchnschr.* 67:306, 1955*

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DISCIPLINARY BOARD BEGINS POLICING DOCTORS

It was the disciplinary board itself that initiated proceedings in its first two cases. They revolved around a Spokane obstetrician, Dr. Jean D. Kindschi, and a Sequim general practitioner by the name of Dr. Robert E. Barker.

Both men had been convicted in Federal court of evading income taxes. Both had paid \$5,000 fines. Both had been sentenced to prison—Dr. Kindschi for four months, Dr. Barker for two years. Both were brought before the board on the ground that they'd been found guilty of a crime involving "moral turpitude." And both men fought the charges.

Double Jeopardy?

Dr. Kindschi's lawyers produced letters from ten prominent Spokane and Seattle physicians attesting to the accused practitioner's high professional standards.

The lawyers also introduced some fifty letters from Kindschi's patients. (Said one: The physician was badly needed in Spokane; his waiting room had been full on the very day he was released from prison; and "Dr. Kindschi already has paid the penalty for his mistake.")

But the lawyers' main line of defense was this: Evading income taxes didn't reflect any "moral turpitude." Many persons commit this minor offense every year, one of the attorneys asserted; but only a few are prosecuted. The sole reason Dr. Kindschi had been brought before the board, said the lawyers, was that "he had been caught."

They Asked to Testify

Dr. Barker's lawyers also contended that their client was innocent of "moral turpitude." And they produced a resolution passed by the physician's county medical society in support of this position. In addition, two prominent Washington doctors asked to testify personally in Barker's behalf. One was Dr. James L. McFadden, a member of the State Legislature and a co-sponsor of the Medical Disciplinary Act. The other was Dr. Quentin Kintner, a trustee of the state medical association.

A Misunderstanding

Dr. McFadden said he didn't think Dr. Barker should have been convicted in the first place. Dr. Kintner said: "All doctors wanted the disciplinary board—

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DISCIPLINARY BOARD BEGINS POLICING DOCTORS

but we didn't think it was going to apply in income tax cases. We thought it would be limited to matters like abortions and narcotics."

Finally, the assistant Attorney General who prosecuted the two cases recommended that the two doctors get only reprimands. Nothing in their records indicated they were professionally incompetent, he said.

Why They Tried Them

Earlier, however, his superior had ruled that income tax evasion was an offense involving "moral turpitude."

And the three members of the Medical Disciplinary Board

who served as a hearing committee had called the hearing because of that ruling. Asked one board member of a fellow physician who testified in Dr. Barker's behalf: "Do you think a dishonest [personal] act can be divorced from [correct] professional conduct?"

He Said 'Yes'

The doctor in question answered in the affirmative—but the committee obviously disagreed with him. So did the full disciplinary board. After studying the full transcripts of the two hearings, the board ordered both doctors' licenses suspended for the ensuing eight months.

Dr. Barker accepted the ver-



MEDICAL POLICEMEN: Members of Washington State's Medical Disciplinary Board include (from left): Dr. Jesse Read, Dr. John E. Downing, Dr. James H. Berge, Dr. W. C. Moren, Dr. Clyde Hutt, and Dr. Marc Anthony.

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DISCIPLINARY BOARD BEGINS POLICING DOCTORS

dict. Dr. Kindschi appealed to the courts—and lost his first bout. Now he's appealed to Washington's Supreme Court.

But Washington's doctors haven't stopped arguing the Kind-schi-Barker case among themselves. Not a few of them are in hot agreement with the many physicians who supported Kind-schi and Barker. They think the two practitioners were penalized unjustly.

Says one G.P.: "A number of people—both laymen and doc-

tors—try to evade part of their income tax. Such evasion has nothing to do with the practice of medicine or a physician's relations with his patients."

'It Had to Be Done'

Many another physician, though, contends that the disciplinary board had no choice but to impose the suspensions. Says one surgeon: "Doctors must be above reproach. If we're going to appear before the public as a profession that's known for its



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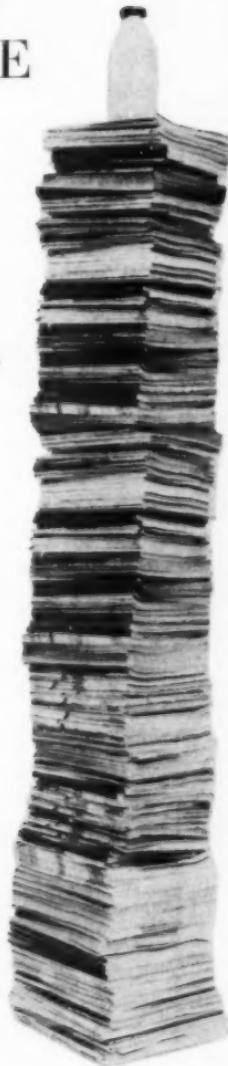
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DISCIPLINARY BOARD BEGINS POLICING DOCTORS

integrity, we must show that we ourselves are doing our utmost to punish all who stray from the straight and narrow.

"Both these doctors were guilty of penitentiary offenses. Neither appealed his conviction by the Federal court. Had the disciplinary board not punished them, it might as well not have been organized. A reprimand would have been a mere slap on the wrist—and the worst possible public relations for the medical profession."

A number of the state's medical leaders were immeasurably

relieved when the board was upheld by the court in the Kindschi case. If Dr. Kindschi's first appeal had been granted, they believe, the board might have become just another noble experiment—subject to successful challenge by any doctor who disagreed with its decisions.

Will It Be Copied?

Now, however, it seems likely to remain an effective disciplinary force. As such, it may serve as a strong precedent for setting up similar boards in many other parts of the country. END

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Should You Buy a Farm as an Investment?

Could be, say the writers, but only if you avoid the snags that many medical men run into. Here are some things to think about before you decide

By Hartley and Rosella Howe

There are good reasons why owning a farm appeals to many Americans, despite the availability of such competing investments as bonds, stocks, mortgages, bank deposits, and commodities. You can't spend a hot August week-end in the shade of 100 shares of A.T.&T. Nor can you use them to teach your children and grandchildren about nature.

To the doctor in particular, a farm offers challenging diversion as well as relaxation. But farming is no simple matter, to be picked up in your spare time. You'd better not go into it thinking you can make a lot of money, or that you can run a farm without any experience or background.

So before you rush to answer that enticing ad under "Farms and Acreage" in the Sunday paper, here are some questions to think about. The answers are taken from agricultural studies, from the comments of farm experts,

and from the experience of many doctors who have invested in farms. (But remember that farms are like women: No two are exactly alike.)

Is a farm a sound investment?

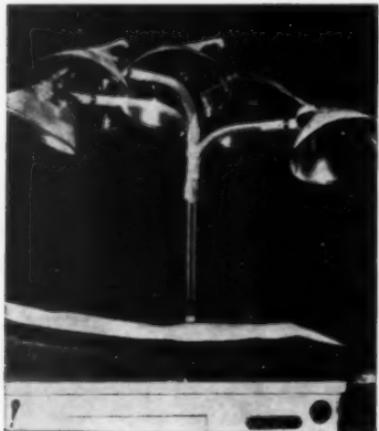
There's one thing about it: Nobody can put a farm in his pocket and walk away with it. Just the same, its investment value *can* fly out the window if you're careless about maintenance and good cropping practices.

Like any real property, farm land tends to increase in dollar value during inflation, despite crop surpluses and falling farm prices. For current income, however, farms rate poorly in comparison with other investments today.

Over the entire country, farm income has dropped 26 per cent in the last five years. Yet the farmer must now pay more than ever before for his equipment, help, gasoline, and supplies. Before World War II, for example, a Kansas wheat farmer paid \$1,200 for a four-plow tractor; today he must plunk down \$4,000 to \$5,000 for it.

The outlook for farm investment income depends on who wins the race between our rising population and our rising crop production. The experts themselves don't agree. Department of Agriculture economists generally predict that production and demand will be in balance after five years or so; but the National Planning Association expects farm surpluses to double by 1965, because of increased productivity.

Still, regardless of what happens, farm income is a political issue. It's unlikely that Washington will ever al-



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formulated for the stress of
pregnancy.

Natalins-PF are formulated
for the busy, modern woman.
The capsules are small,
attractive, easy to swallow.
Just one to three capsules daily,
according to need,
help supply the increased
requirements for vitamins,
iron and calcium in pregnancy.

For some patients, you may
prefer to prescribe Natalins®
which contain *both* calcium
and phosphorus.

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SHOULD YOU BUY A FARM?

products, farm real estate prices have continued to rise. This is only partly the result of general inflation. The demand for farm land is high because farmers themselves are expanding their holdings: It takes a lot of acreage to make expensive machines pay off.

And there's little new farm land available today outside certain reclaimed areas in the West and South.

How much money does it take to buy a farm?

Probably more than you think. A doctor in a Midwestern state

reports that the purebred herd on his dairy farm represents an investment of over \$2,000 a head. This is higher than average. But even at half as much, it represents a lot of capital, since experts say the minimum number of cows in today's efficient dairy farm is fifty to sixty.

In poultry farming, the total investment per hen may be \$10 or \$12. But the birds must be reckoned by the thousands. And an apple orchard of several thousand trees may have \$10 or \$15 invested in each tree.

Land prices start at next to

FUNDAMENTAL THERAPY IN PEPTIC ULCER

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AMPHOJEL®
ALUMINUM HYDROXIDE GEL

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With evaporated milk, the doctor *prescribes* the formula best for the baby, and changes it as he grows. Each infant has the advantage of his own, individual *prescription* formula.

Carnation
"FROM CONTENTED COWS"

Optimum prescription-quality in today's trend to the individualized formula.



SHOULD YOU BUY A FARM?

nothing and climb into the stratosphere—and you get what you pay for. Some Western range land sells for as little as \$10 an acre; but the Western rancher must figure on twenty-five acres to feed each cow. In parts of New York State, where it takes only three acres to feed a cow, the price per acre reflects the difference.

Prices per Acre

In the Corn Belt, prices run about \$250 to \$350 an acre. You can find yourself paying as much as \$600 to \$1,000 an acre in ir-

rigated or citrus areas and in the bluegrass country of Kentucky.

According to one professional management company, the lowest-priced Eastern farm practicable for an absentee owner would cost about \$65,000. The median price for such farms is \$150,000. And they *can* go as high as \$400,000.

The average farm in Willamette Valley, Ore. was worth \$75,000 a few years ago. The average Iowa farm (about 260 acres) has about the same value.

All the above figures are for farms complete with stock, equip-



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in attractive
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It doesn't take long for the below-par child with an eating problem to respond to delicious, cherry-flavored 'Troph-Iron'. This potent combination of Vitamin B₁₂, B₁ and iron is designed to stimulate appetite, promote growth and correct nutritional iron deficiency.

'Troph-Iron' is available in both liquid and tablet form. Each 5 cc. teaspoonful of the liquid and each tablet supplies 25 mcg. Vitamin B₁₂, 10 mg. Vitamin B₁ and 250 mg. ferric pyrophosphate.

Troph-Iron* | B₁₂-iron-B₁

Smith, Kline & French Laboratories, Philadelphia

*T M. Reg. U.S. Pat. Off.

SHOULD YOU BUY A FARM?

ment, and—in some cases—one year's operating capital. Roughly half of each valuation represents the cost of land and buildings.

How much cash do you need, and where can you get credit?

In general, you need 30 to 50 per cent cash, plus working capital. Insurance companies and banks are the best bet for a mortgage. If the farm you want to buy is really a sound business, you'll find the local bank willing to lend you money.

While the farm lending agencies of the Government were set up chiefly to aid veterans who want to go into farming, or work-

ing farmers who need help, these agencies will usually lend money to any experienced farm owner. Sometimes their requirements are harder than the insurance companies'. But in some sections of the country they may be the only source for loans.

What return can you expect on your money?

That depends. Says a New Jersey doctor: "It's a wonderful feeling to eat your own butter and eggs and drink your own milk and enjoy your own broilers. But they cost you five times what you can buy them for in a store."

This man is no longer farming his land; he's simply "enjoying

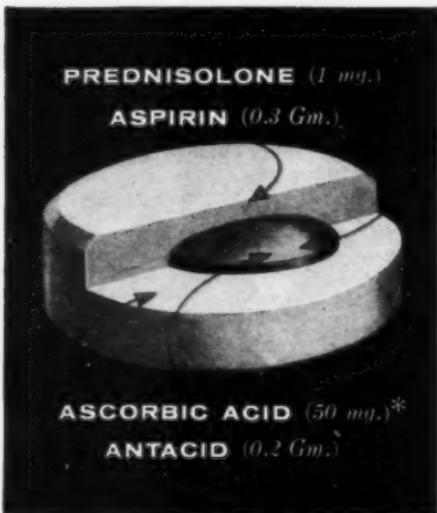


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With TEMPOGEN, many patients obtain adequate relief from immobilizing "rheumatic" pain with lower hormone dosages than are ordinarily required, because of the enhanced antirheumatic effect provided by the prednisolone-salicylate combination. In addition, the likelihood of the occurrence of gastric distress or adrenal ascorbic acid depletion is minimized.

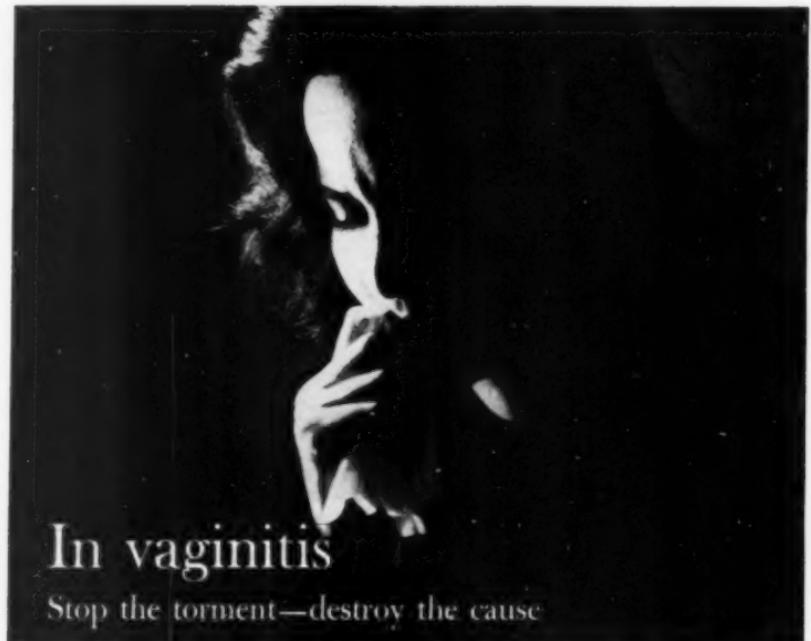
INDICATIONS: Early rheumatoid arthritis, rheumatoid spondylitis, osteoarthritis, Still's disease, psoriatic arthritis, bursitis, synovitis, tenosynovitis, myositis, fibrositis, and neuritis.

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*present as 60 mg. sodium ascorbate



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AVC *Improved*



in trichomonal vaginitis —
" . . . the most effective
treatment available."¹



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" . . . more effective
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in mixed infection —
" . . . the most effective
treatment of endocervicitis. . . ."³

The rate of cure with AVC Improved is consistently high in all common types of vaginitis. In one series of patients with trichomonal vaginitis, bacteriologic cures were obtained in 82.5% of the cases.¹ Symptomatic relief is rapid and lasting. And because AVC Improved has an acid pH, it encourages the early return of normal vaginal flora.

Composition: A nonstaining cream containing 9-aminoacridine hydrochloride 0.2%; sulfanilamide 15.0%; allantoin 2.0%; with lactose in a water-miscible base buffered to pH 4.5.

Indications: Trichomonal leukorrhea; monilial and nonspecific vaginitis; cervicitis; postpartum hygiene; pre- and postcauterization, coagulation, conization, and other vaginal surgery; vaginal infections in children.

Administration: An applicatorful twice daily — on arising and at bedtime.

Supplied: 4 oz. tubes with or without applicator.

- (1) Cortese, J. T.: Clin. Med. 2:45, 1955.
- (2) Hensel, H. A.: Postgrad. Med. 8:293, 1950.
- (3) Horoschak, A. and Horoschak, S.: J. M. Soc. New Jersey 43:92, 1946.

Products of
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THE NATIONAL DRUG COMPANY
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SHOULD YOU BUY A FARM?

the beautiful scenery. Still," he adds, "my family wouldn't want to have missed all the excitement and pleasure, the practical experience, and the hard knocks of the years of active farming. They were worth all the money and energy spent."

Note, however, a farm management concern's statement that a well-chosen, well-managed farm is a better investment than common stocks—if the returns are averaged over a number of years. The company cites an Ohio investor who purchased a rundown farm some years ago. He says: "The return on my investment has run as high as 18 per cent, and it's averaged about 10 per cent." (These figures undoubtedly include the abnormally prosperous war years.)

Income Yardstick

One very rough yardstick for judging returns is the return the average farm landlord receives for acres he rents for cash. Over the years, such rents appear to approximate whatever the banks get as interest on farm mortgages—currently about 5 per cent.

Are there tax advantages in investing in a farm?

A New England doctor reports

that he'd be operating his farm at a loss "if it weren't for the tax advantages of repairs and depreciation on machinery."

On the other hand, a farm management man points out, operation of a farm at a loss may be a tax advantage if the farm has a profit potential:

The Tax Angle

"Today practically all doctors are paying substantial income taxes. If a run-down farm is purchased, repairs and other rehabilitation costs are deductible on tax returns. If the owner is in the 80 per cent bracket, these improvements cost him but 20 per cent of the current charge. If repairs are necessary, they should add 100 per cent of their cost to the value of such a farm. These repairs may be made through a term of years when the owner is enjoying the highest income of his life, in order to improve the farm's income during his years of retirement."

But if you buy a run-down farm, make sure its condition is due to poor management or lack of capital.

If, instead, it's run-down because of unchangeable defects like gradient, poor soil, lack of

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SHOULD YOU BUY A FARM?

market, or inadequate water supply, you'll be in the soup.

What's the best kind of farm to buy?

There are nine major U.S. farming regions. In each, the climate and the soil are best adapted to certain types of farming. The safest choice would be one of the prevailing types in your area.

In the Middle West, for instance, corn or beef cattle or dairy farming might be your choice. South and east of the Corn Belt, in the bluegrass areas

of Kentucky and Tennessee, the Virginia Piedmont, and the Appalachian Highlands, you might choose livestock or tobacco. In the Southeast, you'd consider cattle, timber, or citrus production.

They're Changing Over

Some sections of the country are changing from one kind of agriculture to another. Many former cotton farmers in Georgia are now raising sheep. Some newly irrigated land in the Southwest is being used for cotton. In New York State, long famous for dairy



"Because of me, his associate switched to geriatrics."

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In Angina Pectoris *when every moment counts*

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- Each measured dose of Medihaler-Nitro delivers 0.25 mg. of octyl nitrite, equivalent in vasodilating action to 1/100 gr. nitroglycerin.
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Note: First prescription should include medication and Medihaler Oral Adapter.



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Reduces incidence and severity of anginal attacks. Each long-acting tablet contains pentaerythritol tetranitrate (PETN) 10 mg. and Rauwiloid® (alaseroxylon) 1 mg. Patients on Pentoxylon suffer fewer anginal attacks.

Riker
LOS ANGELES

SHOULD YOU BUY A FARM?

herds, beef cattle are becoming important.

"The Corn Belt areas of Ohio, Indiana, and states to the west," says one farm management executive, "offer investors farms as productive as can be found anywhere . . . These farms merely need sound management to bring them to high production. Many can be bought at prices well below those prevailing in the Corn Belt as a whole . . .

Bargains—Maybe!

"In Georgia, the Carolinas, Alabama, and Florida, large acreages needing rehabilitation (which requires both management and capital) are available at reasonable prices."

Then, too, there are specialty farms in most parts of the country—fruit orchards, truck gardens, cranberry bogs. But in general such specialty crops, while returning a high net per acre, demand the kind of intensive personal management that an absentee physician can hardly give them.

It's best, say the experts, for an absentee owner to stick to "extensive" types of husbandry—such varieties as beef cattle or general farming.

How can you find the right farm?

The safest way, probably, is to call in a professional farm appraiser before you buy. But don't call on one unless you're serious about the place: The fee may be as much as \$100 a day.

One doctor who was considering buying a 320-acre farm was horrified when an appraiser told him his fee would be \$50 a day—and that the job would take at least a day. So the doctor did his own appraising. And after managing the farm himself for two years, he gave up and sold it at a loss of \$6,400.

Buying Information

To get a line on available buys, you might consult such national real estate agencies as the Strout Agency, American Listings, Previews, etc. Their farm listings from all over the U.S. are particularly helpful if you're looking for a rural place in a far-away locale.

In addition, the land grant college or agricultural experiment station in each state has experts on land utilization who can supply information on farm possibilities in the area. And on a more local level the County Agent may

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vaginal gel

SHOULD YOU BUY A FARM?

be helpful, if local farm real estate agents can't find what you want for you.

Whom can you get to run the farm for you?

"Many business and professional people," says a well-known economist, "buy farms as a business investment and—perhaps because they were country-bred—figure they know all about how to run a modern farm. They don't understand that farming has changed completely even in the last ten years. The farm they knew as a boy is as out-of-date as last year's Easter hat."

A few tons of the wrong kind of chicken feed or a chemically unbalanced fertilizer may make the difference between profit and loss for the year. Decisions when to sell or hold, what to buy, when to borrow, whether to buy machinery or livestock or spend the money to improve pastures—all these determine whether or not a farm is to be profitable.

Management Help

There are farm management firms in key spots throughout the country. Most of them belong to the American Society of Farm

Maternity patients get greater comfort and relief from VULVA VARICOSITIES with NU-LIFT natural "HAMMOCK" Shoulder Strap Support

Designed by a doctor...with exclusive patented shoulder straps that let shoulders carry much of the added weight. A feeling of lightness and buoyancy results from a special obstetrical front, that provides gentle abdominal lift from underneath, without uncomfortable boning.

Pelvic pressure is reduced, backache relieved, possibility of varicose veins lessened as elevation of baby improves posture.

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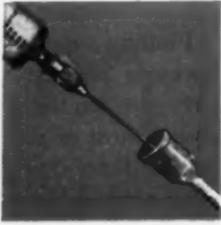
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SHOULD YOU BUY A FARM?

Managers and Rural Appraisers. The society, headquartered in Storm Lake, Iowa, publishes a list of its members and their addresses.

What You Get

Complete management service by such a firm would include setting up a plan of operation to fit your farm, your budget, and your objectives; finding a capable manager to run the farm for you; and close supervision of his work. The service would do everything, in fact; and it would give you regular financial reports.

There are other possible arrangements: sharecropping, found mostly in the Southeast; renting to a tenant farmer; hiring a managing farmer; establishing a partnership. An outstanding New York beef cattle farm is owned by two men. One of them lives and works in New York City. The other lives on the farm and runs it.

Your Hired Hands

Finding superior employees is always a problem, and particularly so when the owner must be absent most of the time. Still, it can be done. One New England doctor whose farm is close to his

practice was lucky enough to find a factory worker who longed to be a farmer but had no capital. The man is doing a wonderful job of managing the doctor's farm.

A California doctor who invested in an almond orchard was less fortunate: His first hired manager had to be dismissed for inefficiency; his second failed to report all the income of the orchards. The doctor now admits he'd have done better to engage the dependable services of a farm management company.

Jackpot Question

How can you make your farm show a profit?

Good management is crucial. A farm management company executive says: "Professional men certainly have their own opinions as to how to carry on their professions. But they often feel that farming is so lowbrow that any individual can do it. Thus what should be a sound investment of \$100,000 is usually wasted in a short time."

A Pennsylvania doctor, for example, was more concerned with esthetics than farm efficiency. He insisted on having his new farm buildings where he could gaze at

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Dose: 1 tablet 2 or 3 times daily.

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SHOULD YOU BUY A FARM?

them from his study, without regard to the working of the farm. As a result, his cows have to walk half a mile from pasture to barn. And his professional manager has despaired of ever showing a profit.

The successful farmer uses his labor and his machinery on the maximum possible number of production units. He utilizes the findings of agricultural science, keeps in touch with his County Agent, is willing to try new methods and new equipment.

Two similar farms in Iowa, operating in the same recent year

under the same conditions, had net incomes respectively of \$596 and \$7,169. The low-income farm actually has better soil; but the high-income farm has a cropping system that's better adapted to the land. And it uses more modern techniques of soil management.

What Doctors Report

The modern techniques do pay off. An Illinois doctor-farmer, for instance, says his \$3,000 electric feed-grinder is the best investment he's ever made. He has 2,000 laying hens, and they eat

Not a sulfonamide, not an antibiotic, URITRAL exhibits wide-range bactericidal action plus prompt analgesia in cystitis, pyelitis, pyelonephritis, and prostatitis without sensitization, crystalluria, emergence of resistant strains; prophylactic against bacilluria due to instrumentation or surgery. Provides antibacterial action of calcium mandelate and methenamine (preacidified), plus phenylazo-diamino-pyridine hydrochloride for analgesia.

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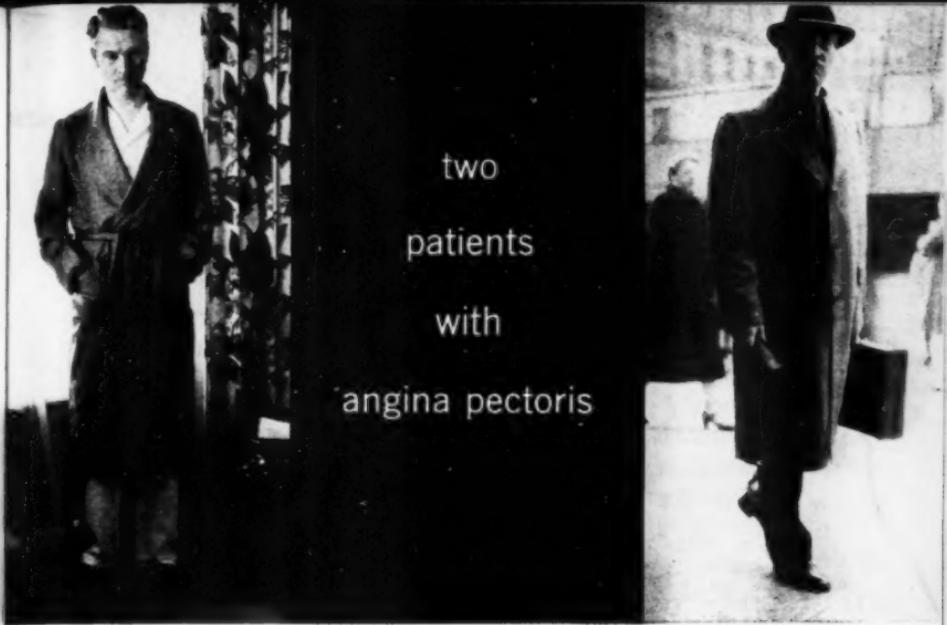
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two
patients
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... your treatment can make the difference

In angina pectoris: "... the difference between complete, or almost complete, absence of symptoms, or a prolonged illness with much suffering" may lie in routine prophylaxis with Peritrate.¹

New studies continue to confirm the effectiveness of this long-acting coronary vasodilator. "Impressive and sustained improvement" is observed in patients on Peritrate therapy.²

Simple prophylaxis: Peritrate is not indicated to abort the acute attack (nitroglycerin is still the drug of choice). However, you can reduce or eliminate nitroglycerin dependence and provide continuing protection against attacks of angina pectoris with Peritrate. Prophylaxis is simple: 10 or 20 mg. of Peritrate *before meals* and at bedtime. Maintenance of a continuous daily dosage schedule is important for successful therapy.

Peritrate has been demonstrated to pre-

vent or reduce the number of attacks, lessen nitroglycerin dependence, improve abnormal EKG findings and increase exercise tolerance.^{3,4,5}

The specific needs of most patients are met with Peritrate's five dosage forms: Peritrate 10 mg. and 20 mg. tablets; Peritrate Delayed Action (10 mg.) for continuous protection through the night; Peritrate with Phenobarbital (10 mg. with phenobarbital 15 mg.) where sedation is also required; Peritrate with Aminophylline (10 mg. with aminophylline 100 mg.) in cardiac and circulatory insufficiency.

Usual Dosage: 10 to 20 mg. *before meals* and at bedtime.

References: 1. Rosenberg, H. N., and Michelson, A. L.: Am. J. M. Sc. 230:254 (Sept.) 1955. 2. Kory, R. C., et al.: Am. Heart J. 50:308 (Aug.) 1955. 3. Winsor, T., and Humphreys, P.: Angiology 3:1 (Feb.) 1953. 4. Plotz, M.: New York State J. Med. 52:2012 (Aug. 15) 1952. 5. Dailheu-Geoffroy, P.: L'Ouest-Médical, vol. 3 (July) 1950.

Peritrate®
(brand of pentaerythritol tetranitrate)

WARNER-CHILCOTT

SHOULD YOU BUY A FARM?

half a ton of feed a day. He saves \$30 a ton by grinding the feed himself. At this rate the grinder paid for itself in 200 days.

There are always short cuts. A Connecticut doctor saves money by buying tractors and farm machinery at auctions "where one can frequently get unusual bargains when other gentlemen farmers decide to give up."

Another doctor, who grows Christmas trees, says: "I have a friend who operates a large chicken farm, and he gives me all the fertilizer for merely hauling it away. This has proved very

valuable in improving my hay land—and, of course, it's a great saving."

Ideas Pay Off

A recent study of management in a selected number of farms shows how a few practical changes in management methods can increase production and income. In three years, the average net income of the participating farms went up more than \$1,000. Milk production increased 32 per cent.

Obviously, as conditions are today, a farm isn't a sure way to

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added certainty
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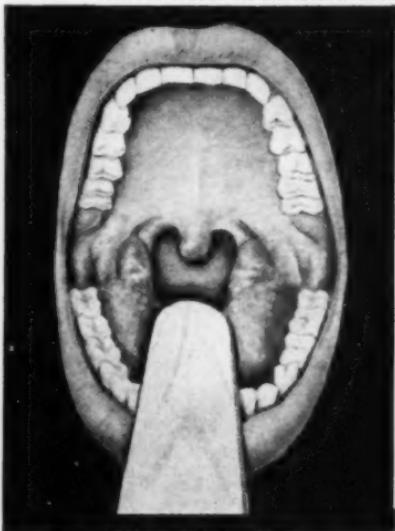
... and for a new maximum in palatability

New mint-flavored Sigmamycin for Oral Suspension, 1.5 Gm. in 2 oz. bottle; each 5 cc. teaspoonful contains 125 mg. (oleandomycin 42 mg., tetracycline 83 mg.).



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"...effective...in the treatment of a variety of infections seen regularly by the practicing clinician..." including pharyngitis, bronchitis and other respiratory infections

and "... often useful in the treatment of infections due to staphylococci resistant to one or several of the regularly used antibiotics"

*"side effects... [are] notable by their absence"**

1. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957. New York, Medical Encyclopedia, Inc., 1957, p. 51.

SHOULD YOU BUY A FARM?

make money. But one thing that distinguishes it from your other investments is the opportunities it provides for personal pleasure. Whether you take advantage of such opportunities is up to you. Says the head of the American Society of Farm Managers and Rural Appraisers:

Tale of Two Doctors

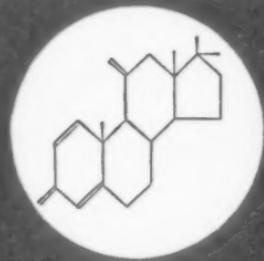
"I happen to manage farms for two physicians who live here in Storm Lake. One of them gets a great deal of pleasure from driving to his farm and looking it over, just to get away from a busy

practice. The other one cares little about that part of ownership. What he wants is a monetary return."

Regardless of your primary motivation, you may find yourself taking more and more personal interest in your farm investment. If you do, you'll probably discover for yourself what a lot of other doctors have already learned: that you've put your money into something more important than land and buildings, animals and machinery, profit and loss. You've actually invested in a way of life.

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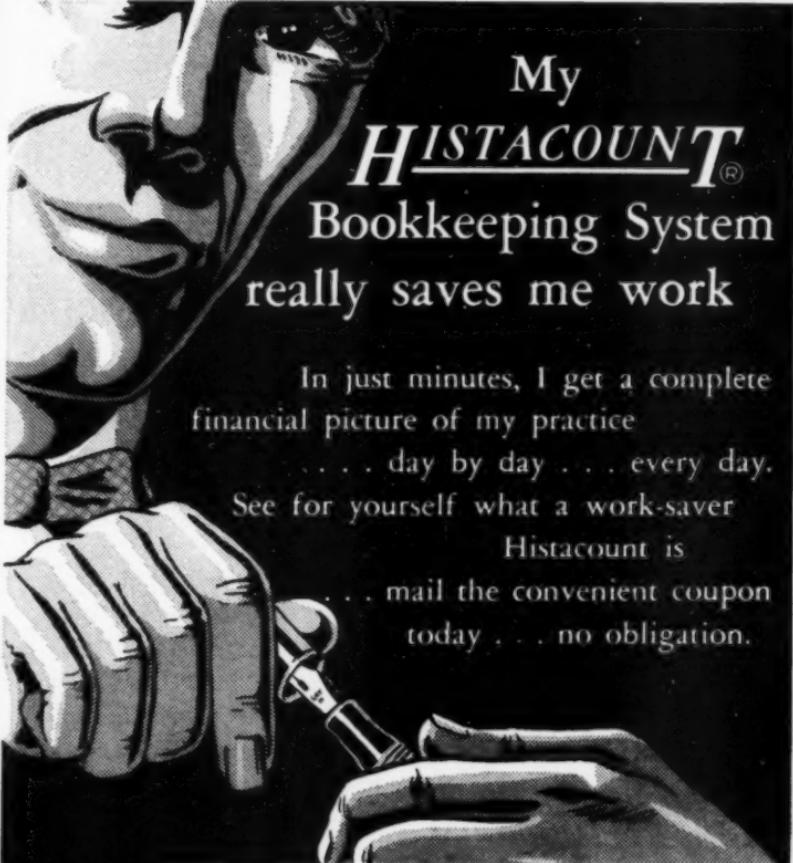
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for biphasic
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*combats corticosteroid-induced
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1: Bolet, A.J., Black, R., and Bunim, J.J.: J.A.M.A. 198:459 (June 11) 1965.



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Why More Doctors

The spread of salaried practice seems sure to continue. Here's the consensus of fifty medical leaders as to its probable effect

By Edwin N. Perrin

Of all the medical school graduates in the class of 1915, only a handful even considered going into salaried practice at the time of graduation. But 15 per cent of the class are drawing full-time salaries today.

Of their younger colleagues who graduated in the class of 1945, an estimated 5 per cent planned a salaried career. But 27 per cent of that crop of doctors are now wholly on salary.

What about still younger classes? It seems a fair bet that at least 40 per cent of their members will wind up in full-time salaried positions.

Doctors on salary are not just here to stay; they may be tomorrow's medical majority. To see what's bringing about this minor revolution, MEDICAL ECONOMICS has questioned fifty of the nation's best-informed medical leaders.

Somewhat less than half the doctors queried are now on salary themselves. Among them are hospital chiefs of staff, medical school deans and faculty members, medical

ors Are Going on Salary

directors of large and small companies, research men, and salaried members of medical groups. The other half are top men in fee-for-service practice, including quite a few medical society officers.

The following discussion of the past, present, and future of salaried practice is based chiefly on the consensus of these fifty men.

Nearly all of them explain the rise of salaried practice in terms of doctors' attitudes. To quote a privately practicing surgeon who's out of sympathy with the trend: "Today's young M.D. wants security. He wants leisure. And unlike the doctor of the past, he isn't willing to work for these things. He wants to start out with them. So he takes a salaried post."

This same surgeon tells a revealing story about his own family:

"My son is a trained cardiologist, one of Paul White's boys. He could have stayed in White's group. Instead, he decided to come home and start his own practice. He did, and he stuck with it for two years. Then he made up his mind he was working too hard for too little return. So he got a job as cardiologist for a big insurance company.

"Now he has no worries, a forty-hour week, a good many holidays off, plenty of time with his family. I can't

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Stein, I. Annals of Internal Medicine 45:185, 1956.

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DOCTORS ON SALARY

really approve of his decision. But I can see why he decided as he did."

It's not the desire for security alone, though, that leads more doctors into salaried work. It's also the feeling that they'd prefer to be part of a medical team.

"Thirty years ago," says the medical director of a big closed-panel plan, "the best-qualified men in medicine went into solo practice. Now many of our best young men feel they can serve most effectively in teaching hospitals or in teamwork with salaried groups. Sure, they want security. But even more they want a better professional life."

Labor's Influence

Besides these attitudes among doctors themselves, there appear to be at least five outside factors pushing them toward salaried practice. First, of course, is organized labor.

"Anything management has, the unions want too," explains the head of a labor health center. "There are growing numbers of company doctors. So growing numbers of the unions are insisting on their own medical programs too."

"And they've got the money to pay for them," he goes on. "The time is already at hand when the

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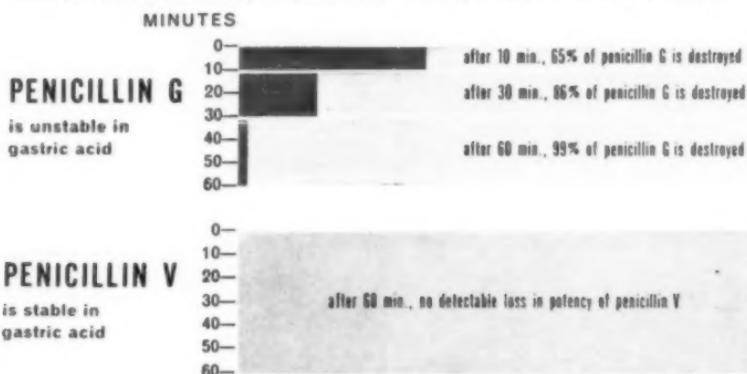
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*Proc. Staff Meet. Mayo Clin., 30:467, 1955; Antibiotics Annual, p. 964, 1955-1956.

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family doctor in some industrial areas makes a better living on a union salary than in solo practice."

A second strong influence: the country's hospitals. To be sure, the big state hospitals have always had salaried staffs; but the number of such hospitals is steadily increasing. Meanwhile, a big change is taking place in nongovernmental hospitals:

Private teaching institutions with salaried staffs are growing in number and influence. Even some general hospitals are beginning to want at least the chief of staff to be on salary. And many doctors in the so-called "hospital specialties" (radiology, pathology, etc.) are already on payrolls.

The third outside factor is the great upsurge in medical re-



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search. More than five times as much will be spent on medical research in 1957 as was spent in 1947. Unlike Sinclair Lewis' Arrowsmith, who kept his microscope and slides in the back of his office, today's research-minded doctor is likely to be on the full-time payroll of a foundation, a university, or a drug company.

Fourth is industrial medicine. "There are more than 3,500 occupational physicians on full-time salaries right now," says the medical director of a company that employs over thirty physicians. "Give us another ten years

and we'll be one of the top five specialties."

Finally, the Federal tax laws are a powerful force in favor of salaried practice. As one well-known G.P. puts it:

"If I work seventy hours a week for myself and net \$40,000 a year, the Federal and state governments let me keep around \$24,000. If I work thirty-five hours a week on a salary of \$20,000 a year, I keep almost \$15,000. Why should I kill myself for the \$9,000 difference—particularly when the salaried job eliminates worry about savings,

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because I know the company will pay me a good pension?"

So much for the reasons why salaried jobs seem sure to attract more and more medical men. Now for a related question: Which doctors seem most likely to be attracted?

The consensus: specialists. The more specialized a physician is, say well-informed observers, the more likely he is to wind up on somebody's payroll.

Why is this so? Well, consider what's happening in some of the major specialties:

Surgeons are now almost en-

tirely independent operators in fee-for-service practice. But the picture is beginning to change. Over the next decade, more and more of them are expected to take salaried posts with hospitals. Many others are bound to become salaried members of groups and clinics. And at least some will work full-time in labor health centers.

Better Pay?

Internists will also move increasingly into the big groups and clinics and into salaried industrial work. Reason: their relative-

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ly low income in solo practice.

Psychiatrists are especially likely prospects for more salaried work. A big reason, according to one such specialist: "Most people simply can't afford adequate psychiatric care, and there seems to be no way to give them insurance for it. So it's inevitable that most psychiatrists will eventually have to be paid by state governments or private foundations."

Radiologists, anesthesiologists, pathologists, and physiatrists already have numbers of their men in salaried hospital jobs. Whether these numbers increase or dimin-

ish depends partly on state laws and ethics codes that are still in flux.

One doctor high in Blue Shield believes that hospital-employed specialists are sure to become independent again—and soon. "The A.M.A. is backing the fight against salaried physicians in hospitals," he says. "And even the Government is sympathetic. The anesthesiologists are coming out from under right now. It's only a matter of time before even the pathologists are free."

But this is a minority view among the fifty medical leaders

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¹ Tompkins, W. T.: In *Modern Nutrition in Health and Disease*, ed. by Wohl, M. G. and Goodhart, R. S., Lea & Febiger, Philadelphia, 1955, p. 885.



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queried. More of them appear to agree with this comment from a medical school dean:

"There's been a tremendous drive to get the specialists off hospital payrolls. But it's had little effect. Very few hospitals have altered their arrangements because of the pressure. I doubt if many ever do.

"In the long run, the hospitals represent more people than the physicians. If the current disagreement ultimately grew into a fight between the A.M.A. and the American Hospital Association —well, I wouldn't bet on the doctors to win."

What of the G.P.?

Most other specialists and most G.P.s are expected to remain fairly immune to the salaried siren song. But even in their case, the trend toward more group practice—and toward the payment of more group members on a salary basis—will almost certainly continue. Industrial medicine, too, will continue its heavy recruiting among G.P.s.

So far we've discussed why salaried practice is on the increase; and we've singled out the fields of practice that seem most likely to fall to the trend. Now let's con-

sider the probable effects on tomorrow's medicine.

The optimists on MEDICAL ECONOMICS' panel (a bare majority) visualize the salary-laden future as a fine one. The employed doctor, they predict, will work much shorter hours with little loss of real income. He'll have fewer business worries and more financial security. He'll have more time for post-graduate study.

'No Near-Starvation'

"Equally important," says one G.P., "is this fact: The beginning doctor won't have to endure years of near-starvation under a salary system. That will give him an emotional as well as a material advantage."

Another emotional advantage is described by an internist in these words: "One of the most unsatisfying things in the whole practice of medicine is to have to arrange a fee for a sick person. If you don't have to worry about it, you can devote your full energies to the service and the scientific excitement. That way, I feel sure, you can practice better medicine."

Possibly he's right. But it's equally possible that, with the in-

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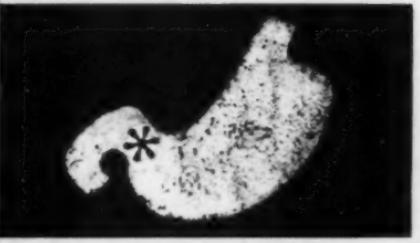
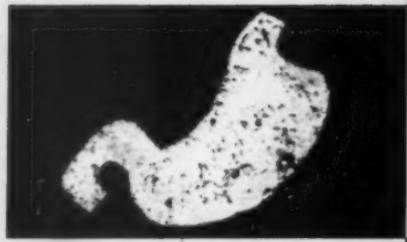
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centive of fee-for-service practice gone, more doctors will practice mediocre medicine. That's the fear most often voiced by those who don't see the future as entirely rosy.

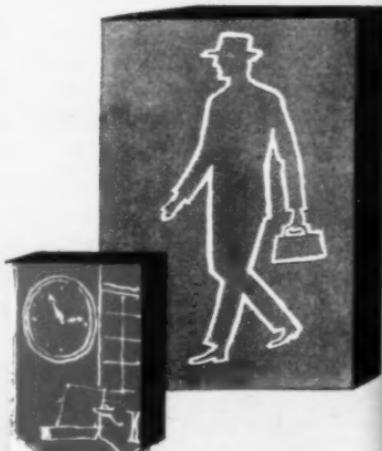
In the first place, they point out, the salaried doctor has no clear-cut financial reason for working hard. "If the reward's the same whether you spend ten minutes or two hours with a patient, which are you likely to do?" asks one pessimist.

Another tells a sobering story on this point. The nurses in his hospital, he says, have recently gone on an eight-hour day and forty-hour week. "They're all on salary, and they get good salaries. But do they want to work even eight hours? No. They manage to spend a good part of each day in the coffee shop.

"Put physicians on salary, and they'll do the same," he maintains. "The universal tendency today is to do as little as you can

Proportion of Salaried Doctors

► This chart shows the ratio between the number of fully salaried doctors (punching time clock) and the number of fully self-employed doctors (walking in background) among physicians who graduated in 1935, 1940, and 1945. For every hundred now fully self-employed, there are twenty-four, thirty-seven, and forty-seven respectively who are now fully salaried. Source: a 1956 study by Weiskotten and Altenderfer.



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for as much money as you can get."

This doctor admits that many a salaried research man or government physician voluntarily works a sixty-hour week: "They'd work hard even if you paid them in jelly beans, because their primary reward is not money but prestige—or the thrill of scientific discovery.

"But I'm talking about the average doctor," he explains. "It's not in ordinary human nature to

work all night for nothing. If you insist on paying doctors for a forty-hour week, what you'll generally get is a forty-hour week."

It appears distinctly possible, too, that salaried doctors may suffer from a loss of professional independence. One medical leader puts it this way:

"Suppose you're self-employed and you want to try a new treatment. O.K., you go ahead and try it. But suppose you're the salaried employe of some health

Shows Steady Upward Trend



Class of '40
Ratio 1:3



Class of '45
Ratio 1:2

DOCTORS ON SALARY

center. And suppose your chief doesn't like your idea. In that case, you either give it up or get tossed out on your ear.

"Doctors, of all people, can't afford to be yes-men. That's why independent practice is an absolute necessity."

Necessity or not, independent practice is clearly losing ground to salaried practice. In ten to twenty years, an anticipated half the country's doctors—and a majority of its specialists—will be drawing at least part-time pay checks. Apparently this will mean great gains in security—

and some losses in incentive and in independence.

Is it possible that the trend will reverse itself? The medical leaders queried don't think so. Several point out that the nation's self-employed practitioners are themselves going along with the trend. In support of this point, more than one man paraphrases a statement by Dr. Max Seham:

"If the nation's medical men really thought that salaried practice produced bad medicine, they wouldn't hire so many of their own M.D. assistants on a salary basis."

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If you get a tax refund, is your return more likely to be audited? When is a gift taxable? Here are facts on several such fine points

By John C. Post

Will my return be audited automatically if I request a refund?

Yes, if you ask for a big one, says the Internal Revenue Service. But—for obvious reasons—the tax men refuse to say what they consider a “big” refund.

Even if you seek a small refund, you may find yourself going through the audit mill. Reason: All returns requiring refunds are set aside so that a sampling of them can be spot checked.

Separate or Joint

Should my wife and I file separate returns or a joint one?

Usually the tax is lower on a joint return. Separate returns would mean a saving for you only under very special circumstances—for instance, if both you and your

THE AUTHOR is a tax and medical management consultant with headquarters in Washington, D.C.

wife had sizable capital losses to report. By filing jointly you could deduct a total of only \$1,000 in losses. By filing separately, on the other hand, *each* of you could deduct up to \$1,000.

Switching Returns

Suppose my wife and I file separate returns for 1956 and wish afterwards that we hadn't. Can we change to a joint return?

Yes. You can switch your 1956 separate returns to a joint one at any time within the next three years (up to April 15, 1960). But if you file a *joint* return this April, you may *not* change to separate returns later.

If you decide to switch from separate to joint returns, ask the Internal Revenue office in your district about the correct procedure to use. In some districts you have to make out a completely new return on the joint basis. But in others, you simply send a letter signed by yourself and your wife to the audit division of the office in your district, stating your desire to make the retroactive change. The tax men then do the necessary arithmetic for you—and they don't even charge you for it!

Taxable Gifts

In appreciation of my obstetrical services, a colleague's wife gave me a handsome instrument bag. Do I have to pay an income tax on it? If so, how do I do it?

Technically, the bag is income and should be so re-

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Strength in construction and the "block and tackle" lacing design of Camp Sacro-Iliac Supports assures its wearer maximum immobility during treatment of low-back conditions. Authorized Camp Dealers serve

your patients with immediate professional fittings in strict accordance with your prescriptions. And your patients benefit from Camp's low prices and high standards of garment comfort.

CAMP
SUPPORTS APPLIANCES

JACKSON, MICHIGAN

TAX QUESTIONS

ported at its market value—that is, at its estimated cost. Actually, tax agents would probably consider the bag a nontaxable gift, since it's clearly a small present and not an expensive substitute for a fee.

Political Gifts

I contributed to the campaign of my Congressman, who has an active interest in legislation affecting medicine. Is this a deductible professional expense?

No. Contributions to political parties, candidates, or organizations concerned primarily with electing candidates are not deductible. But a contribution to an essentially nonpolitical scientific organization—like the A.M.A.—is deductible, even though the organization may use some of the money to help influence legislation, directly or indirectly.

Interest on Taxes

I made an error in my tax return last year and had to pay a deficiency, plus \$175 interest. Is this interest tax-deductible?

Yes. Almost all interest is deductible—even interest on tax deficiencies.

Sale of Old Goods

When redoing my office last spring, I sold some furniture that

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LIPO GANTRISIN

'Roche'

For round-the-clock therapy

With two doses a day

Lipo Gantrisin 'Roche'—a new, palatable liquid for antibacterial therapy—offers three significant features:

1. Only two doses a day needed in most cases
2. Adequate twelve-hour blood levels after a single dose
3. Same therapeutic advantages as Gantrisin 'Roche'

Lipo Gantrisin® Acetyl—brand of acetyl sulfisoxazole in vegetable oil emulsion

Arteriosclerosis of the central nervous system is the commonest cause of vertigo that we see . . . It is usually mild, is often positional and responds poorly to treatment. Dramamine and sedation are often beneficial . . ."

Lewis, M. L., Jr.: The Problem of the Dizzy Patient, New Orleans M. & S. J. 104:161 (Oct.) 1951.



Dizziness in the elderly patient with arteriosclerosis.

for dramatic results
Dramamine®
Brand of Dimenhydrinate

SEARLE

TAX QUESTIONS

I had fully depreciated. Do I have to pay tax on the proceeds of the sale?

Yes. You must treat the proceeds as a long-term capital gain. But note this: If you had used the old furniture as down payment on the new, you would then have technically realized no gain—and have been liable for no taxes. You would then reduce the cost of the new furniture by the amount received for the old, and use this reduced figure as the new basis for figuring the annual depreciation.

STATE TAXES

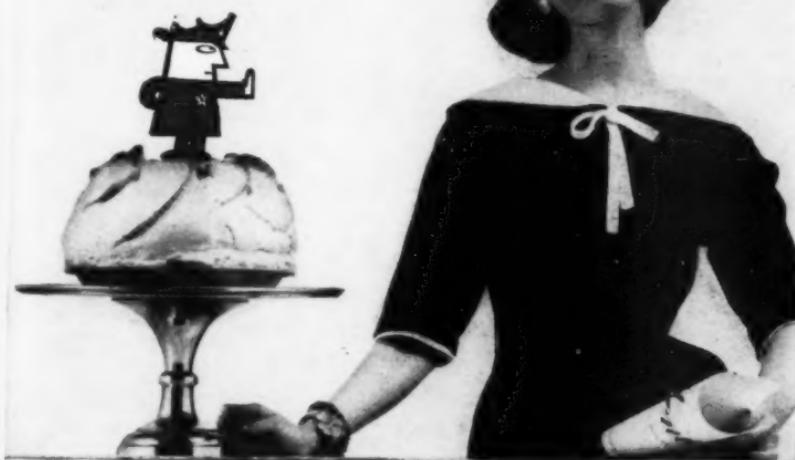
Is it true that all state taxes are deductible from the Federal income tax, and that all U.S. taxes are not?

No. The line isn't drawn that neatly. You may, for instance, deduct the Federal Social Security taxes you pay as an employer; and you may deduct Federal excise taxes whenever the item taxed is itself deductible. (This last would apply, for instance, to telephone service taxed by the U.S. Government.) But you may not deduct Federal income, gift, and inheritance taxes or ordinary Federal excise taxes on nondeductible items.

It's true that state and local income, real estate, and most ex-

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**you
can
police
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patients**



When dietary discipline can't be maintained...

you can safely assign REVICAPS to police
their appetite.

Hunger contractions as well as
subjective feelings of hunger are effec-
tively diminished by REVICAPS.

REVICAPS combine all three accepted
adjuncts to reducing diets: d-amphetamine,
methylcellulose[®], vitamins and minerals.

Include REVICAPS in the reducing regimen
you prescribe.

Available on Prescription Only



R E V I C A P S*

d-Amphetamine · Methylcellulose · Vitamins and Minerals

Dosage: 1 or 2 capsules $\frac{1}{2}$ to 1 hour before meals.

accepted
reducing
medication



LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

*REG. U. S. PAT. OFF.

ANSWERS TO YOUR TAX QUESTIONS

cise taxes are deductible. But local inheritance taxes are not.

Scholarship Funds

My son is attending college on a \$1,500-a-year scholarship. I spend an additional \$1,200 on him. Since I'm thus contributing less than half his support, do I lose him as an exemption on this year's tax return?

No, you may still claim him as an exemption. The value of a scholarship award is disregarded in determining dependency. In this case, the Treasury would consider you to be supplying your son's entire support.

Sale of House

Six years ago I bought a \$20,000

home. Last Nov. 12, I sold it for \$30,000. I've heard that under certain circumstances I may not have to pay taxes on the \$10,000 capital gain. Is this true? If so, how do I handle it on Form 1040?

If the house was used as your residence, and if you plan to put the entire \$30,000 into the purchase of another residence within a year from the date of sale (that is, before Nov. 12, 1957), you needn't pay the capital gains tax. In fact, though you must give details of the sale on Schedule D of Form 1040, you don't even have to report the \$10,000 as gain on your 1956 return. But you may have to pay a capital gains tax later, if you decide to sell the second home.*

One-Hour Baby

Does the Treasury allow a dependency exemption for a child who lived for only an hour after birth?

Yes. The length of time is immaterial. But remember that the exemption is *not* allowed for a stillborn child.

Employe Benefits

A woman who'd been my secre-

*For a fuller discussion of the subject, see "Ins and Outs of the Tax on House-Sale Profits," MEDICAL ECONOMICS, June, 1955.



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NEW
for your
Rheumatoid Arthritis
patient

for the objective symptoms
for the subjective distress

the first
and only
ataractic-
corticoid

Ataraxoid*

provides the anti-rheumatic,
anti-inflammatory action of the most
effective steroid, STERANE®, complemented by
the superior central tranquilizing effects of
ATARAX®. Minimal disturbance of fluid and
electrolyte metabolism; no mental fogging
or major toxicity in ataractic action.

FOR UNMATCHED RESPONSE AND
MANAGEMENT IN RHEUMATOID ARTHRITIS...
AS IN OTHER COLLAGEN DISEASES, BRONCHIAL
ASTHMA, INFLAMMATORY DERMATOSES.

Supplied: Each green, scored
ATARAX® tablet contains 5 mg. prednisolone
(STERANE®) and 10 mg. hydroxyzine hydro-
chloride (ATARAX®). Bottles of 30 and 100.

Pfizer LABORATORIES
Division, Chas. Pfizer & Co., Inc.,
Brooklyn 2, New York

Pfizer

*Trademark



ANSWERS TO YOUR TAX QUESTIONS

tary for the last twenty years died in November, leaving her aged mother to get by on a very small income. At Christmas, I sent the mother a check for \$3,000. Am I correct in assuming she doesn't have to report this as income on her tax return, and that I may claim this amount as a business expense on my own return?

You're right. Any amount up to \$5,000 paid to the survivor of a former employee is—like an insurance death benefit—not reportable as income by the recipient. And you may deduct the amount as a business expense,

just as you deducted your former secretary's salary.

Buying a Practice

I'm thinking of buying a practice from a retiring doctor. May I deduct the price on my tax return?

That depends on what you're buying. If you're paying chiefly for capital assets like furniture and equipment, you can depreciate the cost of these items over a period of years, just as you depreciate the cost of your professional automobile. But if you're buying only goodwill, the cost is not deductible.

END



however YOU see the **constipated patient**

tied up in knots, or otherwise...

zilatone®

TABLETS

**provide judicious, gentle therapy for
constipation and associated discomfort**

ZILATONE is a rational combination of bile salts to promote secretion of the physiologic laxative, bile; mild intestinal stimulants to assure intestinal activity without griping or overstimulation; and digestants to relieve associated dyspepsia.

Available: in boxes of 20, 40 and 80 tablets,
each tablet sealed in sanitary tape.

Samples available to physicians on request.

Drew Pharmaceutical Co., Inc.
1450 Broadway, New York 18

Since daily dosage is an important part of supplementation, GEVRAL is now packaged in a special JUBILEE JAR—an attractive container of 100 capsules for the family dining table. Specify GEVRAL. Your patients will remember to take their "vitamins" regularly when they have the JUBILEE JAR before them at mealtime.

*An ideal
family vitamin-mineral
formula—*

GEVRAL*

VITAMIN-MINERAL SUPPLEMENT LEDERLE

dry filled sealed capsules

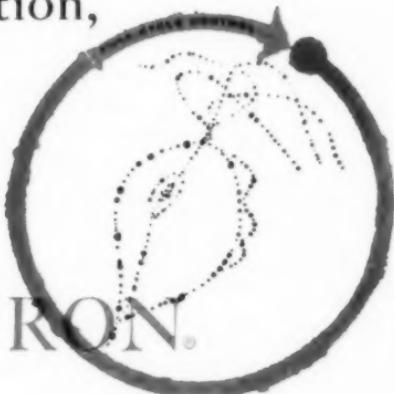


LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK
*U.S. Pat. Off.

Lederle

MEDICAL ECONOMICS · FEBRUARY 1957 261

Even stubborn
trichomoniasis yields...
because Tricofuron
is effective
during menstruation,
the critical time
for therapy.



TRICOFURON.

Recurrences of trichomoniasis "are most likely to follow the menstrual period."¹

"Over and over again today patients are seen with what is said to be an intractable, treatment-resistant Trichomonas infestation, but history-taking often reveals that such patients have never had treatment prescribed during any menstrual period."²

Menstrual blood in the vagina "forms an excellent medium for the rapid multiplication of *T. vaginalis*"³ and "lowers the acidity of the vagina and hence there is a tendency to recrudescence [of trichomoniasis] at that time."⁴

Tricofuron is powerfully trichomonalid "even in the presence of vaginal debris and menstrual blood."³

For 44 of 48 patients: lasting cure was obtained with a single course of Tricofuron therapy.³

Vaginal Suppositories—for home use—each morning and night through one cycle, including the important menstrual days. Contain 0.25% Furoxone® (brand of furazolidone) in a water-miscible base. Box of 12, each sealed in green foil.

Vaginal Powder—for office use—applied by the physician at least once a week, except during menstruation. Contains 0.1% Furoxone in an acidic powder base. Bottle of 30 Gm.

References: 1. Bernstein, J. B., and Rakoff, A. E.: *Vaginal Infections, Infestations, and Discharges*, New York, The Blakiston Company, Inc., 1953, p. 235.
2. Overstreet, E. W.: *Arizona M.* 10:383, 1953.
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NORWICH, NEW YORK

Nitrofurans—a new class of antimicrobials—neither antibiotics nor sulfonamides



Will Medicare Lead To Standardized Fees?

That question has been bothering many a physician. Are such fears justified? Here's what twenty states' fee schedules indicate

By Hugh C. Sherwood

Most doctors apparently want to make Medicare work. At the same time, they're afraid the new medical program for military dependents may be another step toward Federal control over private practice. They're especially wary of Federal standardization of their fees.

These sentiments emerge from a MEDICAL ECONOMICS poll of the forty-eight state medical societies. Something else emerges, too: a sampling of the fees they negotiated with the Defense Department (see page 265).

To what extent do the reports from state societies justify doctors' fears of nationally standardized fees? The evidence to date is that there's wide state-to-state variation in the amounts Medicare will pay.

Of course, Medicare *has* tended to standardize fees for dependent care *within* each state. And some doctors don't like this. According to the Iowa State Medical Society, physicians there found it "difficult to develop a schedule

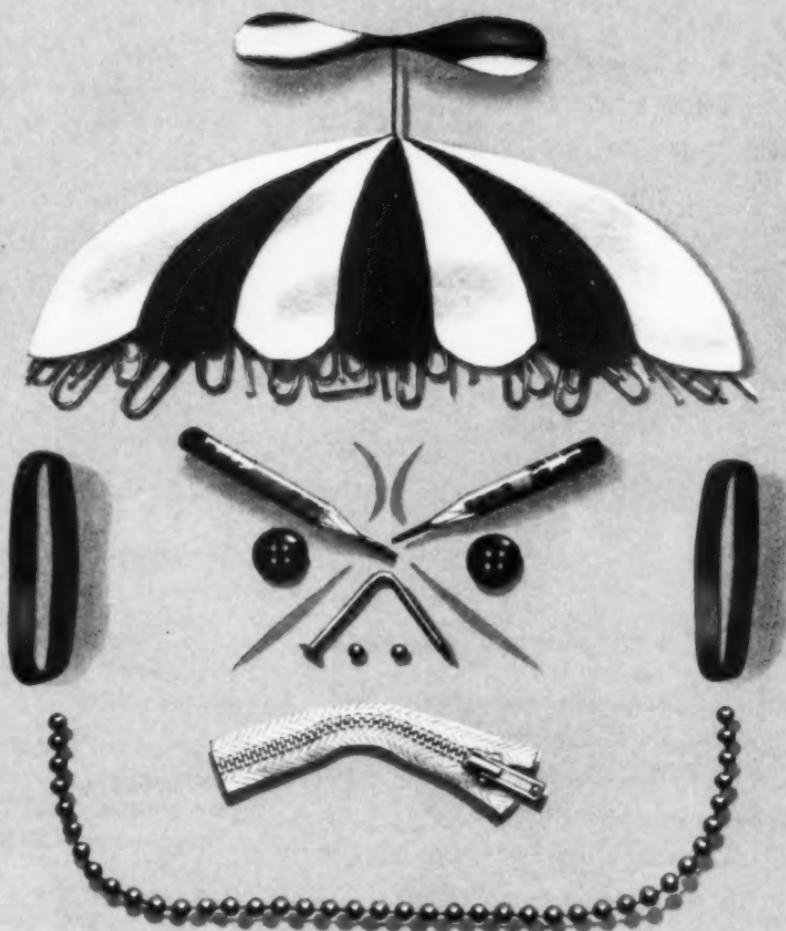


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for natural acceptance of your prescribed contraceptive regimen • fulfills your patient's natural wish that her possessions reflect her femininity. Each Lanteen Exquiset contains: 3 oz. tube of Lanteen spermicidal jelly, soothing, cleanly scented; easy-to-insert, molded, flat spring diaphragm; newly designed *Easy-Clean* applicator; universal inserter — all fitted into a stylish, soft plastic purse.

Lanteen jelly contains ricinoleic acid 0.50%, hexylresorcinol 0.10%, chlorothymol 0.0077%, sodium benzoate and glycerin in a tragacanth base. Lanteen jelly and flat-spring diaphragm sets are distributed by George A. Breon & Company, 1450 Broadway, New York 18, N.Y. (In Canada: E. & A. Martin Research Ltd., 20 Ripley Ave., Toronto, Canada.) Manufactured by Esta Medical Laboratories, Inc., Chicago 38, Ill. *TRADEMARK OF GEORGE A. BREON & COMPANY



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Establish your own
"open door" policy...

And
these "doors"
will always
be open



m-m-m-chocolate!

when you use
this good-tasting
sulfonamide suspension

DELTAMIDE

SUSPENSION/TABLETS

The preferred quadri-sulfa mixture

Your hard-to-please, squeamish patients won't mind "taking their medicine," if it's Deltamide Suspension. The taste of sulfas is completely masked by a delicious synthetic chocolate-like flavor. There is no unpleasant aftertaste. Moreover, Deltamide Suspension can be safely given to children and other patients sensitive to chocolate.

Try Deltamide in urinary tract infections. Action is rapid and side effects rare. Deltamide is economical for your patients.

Each 5 cc. teaspoonful of pleasant-tasting Deltamide Suspension, or each tablet supplies:

Sulfadiazine 0.167 Gm.
Sulfamerazine 0.167 Gm.
Sulfamethazine 0.056 Gm.
Sulfacetamide 0.111 Gm.

Suspension: 4 and 16 oz. bottles

Tablets: Bottles of 100 and 1000

DOSAGE: Average adult dose: Initial, 3 to 4 Gm. (6 to 8 tablets); maintenance, 1 Gm. every 6 hours.

Children: Initial, 0.5 Gm. (1 tablet) per 10 lbs. body weight, followed by $\frac{1}{4}$ the initial dose every 6 hours.



THE ARMOUR LABORATORIES

A DIVISION OF ARMOUR AND COMPANY • KANKAKEE, ILLINOIS

WILL MEDICARE STANDARDIZE FEES?

satisfactory to metropolitan physicians and not increase fees in the rural areas." Some Vermonters have complained that the program "takes away the physician's

right to charge what he wants to."

But most medical societies report themselves reasonably well satisfied with their Defense Department negotiations. Let's see

What Medicare Will Pay In Twenty States

	Obstet- rical Delivery ¹	Appen- dectomy	Colles' Fracture ²	Tonsil- lectomy	Complete Blood Count	Breast Biopsy
Ala.	\$150	\$150	\$75	\$65	\$5	\$100
Colo.	150	125	50	65	5	50
Conn.	155	125	75	60	5	25
Fla.	150	158	68	60	5	45
Iowa	125	150	55	75	5	50
Kan.	150	150	50	65	4	35
Me.	150	150	70	65	5	45
Mass.	150	125	65	50	5	25
Mich.	150	125	50	42.50	5	25
Mont.	130	150	65	65	5	45
N.H.	130	150	75	50	6	25
N.M.	150	140	60	65	5	40
N.Y.	150	150	65	45	5	25
Pa.	150	150	75	50	5	35
S.D.	150	165	75	60	3.50	30
Tenn.	130	150	65	65	4	43
Tex.	150	150	70	70	5	47
Va.	140	150	65	65	5	45
W. Va.	130	150	65	55	5	43
Wyo.	125	125	75	60	7.50	25

¹Including ante- and post-partum care. ²Simple, closed reduction.

Activated Assimilation of Iron

"Our results . . . have been so striking . . . dramatic . . . rapid."¹¹

" . . . a more rapid and constant hemoglobin rise

... with no evidence of toxicity."¹²

Mol-Iron®

Now

Mol-Iron with Vitamin C

*Better tolerated Mol-Iron is now available with vitamin C (75 mg. per tablet), because ascorbic acid has been shown to promote increased absorption of orally administered iron.¹³

Dosage: Adults—2 tablets t.i.d. after meals.

Children—6 to 12 years—1 tablet t.i.d. after meals.

Supplied: Bottles of 100 only.



Well-tolerated—even by patients with a history of iron intolerance.^{3,4}



More rapid maximal hemoglobin response shortens the period of treatment usually necessary with other preparations.



Outstanding efficacy and tolerance is attested by more original investigations and clinical evaluations¹⁻¹⁴ than have been reported for any other iron preparation.

Tablets

ALSO AVAILABLE AS LIQUID AND DROPS



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Dosage: Adults—2 tablets t.i.d. after meals.

Children—6 to 12 years—1 tablet t.i.d. after meals.

Supplied: Tablets in bottles of 100. Liquid in bottles of 12 fluid oz.

Drops in bottles of 15 and 50 cc. with calibrated dropper.

WILL MEDICARE STANDARDIZE FEES?

what's behind the current reports:

Most medical societies took to Washington a fee schedule that reflected elaborate preparations. Massachusetts doctors chose to have their Blue Shield plan draw up their proposed Medicare fee schedule. But in most other states, medical society committees did the job.

How did they decide on specific fees? In some states—e.g., Colorado, Connecticut, and Pennsylvania—they based their schedules largely on those of Blue Shield plans. But in most states they painstakingly determined

going rates within the area. For example, the New Mexico society reports:

"The proposed schedule of procedures was sent to each county medical society. The county societies filled in the average fee for each procedure and returned the schedules to the state society. Then a committee appointed by the state society averaged the charges for each procedure. Finally, the averaged schedule was returned to each county society for official acceptance or rejection."

Each state medical society also

NOW...doubly-high antibiotic blood levels

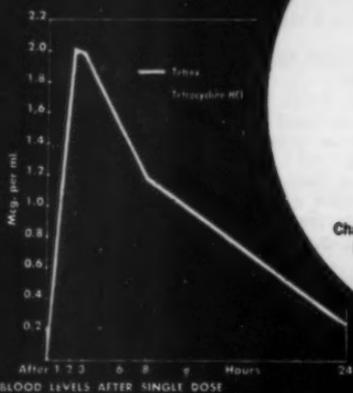


Chart (left) shows
blood levels practically
double with Tetrax

— from 3 independent studies by
P. A. Bunn, M.D., Sol Katz, M.D.,
and G. A. Cronk, M.D., on 198 patients.

Tetra

TETRACYCLINE

—pack

exercised free choice in the selection of a fiscal agent—the local paymaster for Medicare fees. In more than half the states, Blue Shield was selected. In most other states, the state medical society itself will pay doctors. A few states—e.g., Alabama and Louisiana—chose to have commercial insurance companies do it.

What the Fees Indicate

Now let's look at some of the fees that resulted from all these preparations and negotiations. The fees listed on page 265 were culled from the schedules of

twenty states. The variations they show suggest that the medical societies have so far avoided nationally standardized fees.

The smallest differential lies in the various fees listed for obstetrical deliveries (including pre- and postnatal care). Doctors in more than half the twenty states will do the job for military dependents for \$150. Physicians in Iowa and Wyoming receive only \$125; Connecticut medical men get up to \$155.

There's also little variation in the agreed-upon fees for appendectomies. Doctors in most of the

... with a single antibiotic...

trex™
CYCLIC PHOSPHATE COMPLEX CAPSULES

— each capsule equivalent to 250 mg. tetracycline HCl
— average adult dose 1 capsule q.i.d.

A new, single broad-spectrum antibiotic compound — providing faster, higher, more efficient blood levels, practically double those of tetracycline HCl, within 1 to 3 hours after administration.



WILL MEDICARE STANDARDIZE FEES?

states that supplied figures get \$150. The lowest amount is \$125; the highest, \$165.

But beyond OB cases and appendectomies, the spread in fees is marked. For the closed reduction of a simple Colles' fracture, doctors in Michigan, Kansas, and Colorado are paid \$50; physicians in several other states, \$75.

For doing tonsillectomies, Michigan men receive \$42.50; their Iowa colleagues, \$75.

Even for a complete blood count, there's notable fee variation. Doctors in most of the twenty states are getting \$5. But South

Dakota medical men receive only \$3.50, while their Wyoming colleagues are paid more than twice that figure.

Differences in fees for a breast biopsy are even more startling. Doctors in many states receive \$25. But Iowa and Colorado M.D.s get twice that; Alabamans, four times as much.

These striking differences reflect each state's individual approach. They reflect another factor, too:

The Defense Department employed seven different negotiating teams. Some granted the M.D.s

when advancing age calls for routine physiologic support

"therapeutic bile"

DECHOLIN®

just one tablet t.i.d.

- improves liver function
- produces fluid bile
- encourages normal peristalsis

DECHOLIN (dehydrocholic acid, AMES) and
DECHOLIN SODIUM (sodium dehydrocholate, AMES)



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MATROMYCIN®

BRAND OF OLEANDOMYCIN

a new antibiotic to protect patients against infection or superinfection due to resistant staphylococci, particularly in hospitals where resistance is a problem and the causative agent can be determined

"Of 140 strains of *Staphylococcus aureus* isolated from patients [in children's wards], 22 were found to be . . . markedly resistant . . . to erythromycin and in each instance the organism was either quite sensitive or moderately sensitive to [Matromycin]."¹

outstandingly effective and well tolerated in oral dosages

In a series of children with bacterial pneumonia, Matromycin achieved a "quite favorable" therapeutic effect; in the same hospital, "thirteen children with possible *Staphylococcus enteritis* responded readily to [Matromycin]." In all the cases, Matromycin produced "no demonstrable toxic effects."¹

Capsules, 250 mg.; bottles of 16.

¹ Ross, S.: *Antibiotics Annual 1955-1956*. New York, Medical Encyclopedia, Inc., 1956, p. 600.



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LEXIN[®]

(Zoxazolamine, [®] McNeil)

engestic[®] coated

(ENTERIC)

PROMPT RELIEF

IN LOW BACK PAIN

With FLEXIN, "...17 of the 20 patients with post-traumatic muscle spasm of the low back had excellent or good responses."¹

AVAILABLE: Tablets, Engestic Coated, pink,
250 mg., bottles of 36.
Tablets, scored, yellow, 250 mg., bottles of 50.

1. Wallace, S. L.: Zoxazolamine (Flexin) in Low Back Disorders, to be published.

U.S. Patent Pending

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Laboratories, Inc.
Philadelphia 32, Pa.

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WILL MEDICARE STANDARDIZE FEES?

pretty much what they wanted; others insisted on bargaining over nearly every procedure. It seems safe to say that most states wound up by compromising on several procedures. (Both Alabama and Texas, for example, lowered whole sections of their proposed fee schedules after preliminary negotiations with Defense Department officials.)

None the less, medical society negotiators appear more satisfied than not. The Colorado society reports: "Our negotiating team . . . was most pleasantly surprised to find that the Defense Depart-

ment and Army negotiators were extremely cooperative, friendly, appreciative of the problems of state medical societies and private practitioners. They even called to our team's attention several items for which they thought we were suggesting too low a fee."

Adds Dr. Harold M. Camp, secretary-treasurer of the Illinois State Medical Society: "We were in Washington two days, but we didn't encounter any trouble. We thought we were very graciously received."

Among those state medical societies that *don't* like the way ne-

reliable

milk replacement

Gerber Meat Base Formula offers a reliable replacement for cow's or goat's milk since it closely approximates evaporated milk in complete proteins, carbohydrates, fats, minerals—is well-tolerated by even the newborn. Clinical survey* indicated no weight loss or anemia in over 100 infants receiving meat base formula.

To be fed through regular nursing bottles.
Available through druggists on specification.
Gerber Products Company, Fremont, Mich.

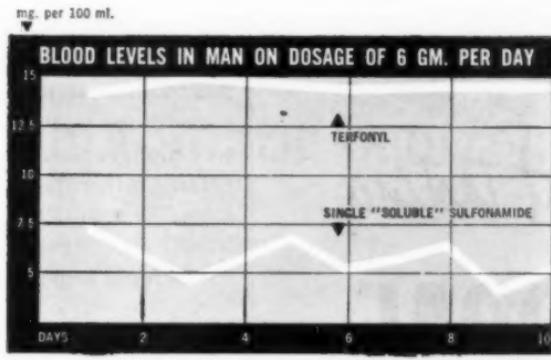
*Rowe, Albert, Jr. and Rowe, Albert H.: *Cal. Med.* 81:279 (Oct.) 1954

Gerber®
MEAT BASE
Formula

maximum efficacy with minimum risk

Terfonyl

SQUIBB METH-DIA-MER SULFONAMIDES



— After Lehr, D., Modern Med. 23:111 (Jan. 15) 1955.

Terfonyl is absorbed as well as single "soluble" sulfonamides, but is eliminated at a slower rate. For this reason, Terfonyl blood levels are much higher.

In experimental infections (Klebsiella, Pneumococcus, Streptococcus), Meth-Dia-Mer sulfonamides have been shown to be from three to four times more effective on a weight basis than single "soluble" sulfonamides.

Toxicity is minimal because normal dosage provides only one-third the normal amount of each sulfonamide. The body handles each component as though it were present alone, although therapeutic effects are additive.

Terfonyl Tablets, 0.5 Gm., bottles of 100 and 1000.
Terfonyl Suspension, 0.5 Gm. per 5 ml., pint bottles.

0.167 Gm. each of sulfamethazine, sulfadiazine and sulfamerazine per tablet or per 5 ml. teaspoonful of suspension.

SQUIBB

*TERFONYL® IS A SQUIBB TRADEMARK



pleasant tasting
AGORAL
for constipation

Whenever constipation complicates therapy, prescribe Agoral . . . for gentle effective laxation.

WARNER-CHILCOTT

MEDICARE FEES

gotiations were handled are Georgia and New Hampshire.

Reports the Georgia association: "The doctors who made up our Washington delegation were unhappy at first about the way they were treated. They were appalled at the Army negotiating team's lack of information about material they sent to it well in advance of the meeting. . . The doctors thought they were at a bargaining rather than a negotiating table." (Eventually the Georgians ironed out their difficulties with the Defense Department.)

Says the New Hampshire society: "The Government representative who headed the team to consider the New Hampshire schedule would not permit many of the fees requested. As a result, the New Hampshire schedule ended up about 20 per cent below that now operating in Vermont. Yet Vermont and New Hampshire [use] the same Blue Shield schedule."

Of special interest to doctors worried about fee standardization is this fact: Some states negotiated what they refer to as "maximum fee schedules." These run higher than the schedules negotiated elsewhere—but the actual figures aren't being publicized, not even among doctors.

M.D.s in such states are sup-

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WILL MEDICARE STANDARDIZE FEES?

posed to charge military dependents their usual fees. These charges will be honored as long as they're under the maximums listed on the special schedules. At least four states are operating on this basis: Georgia, Illinois, Minnesota, and Wisconsin.

One more bit of evidence pointing away from fee standardization: Indiana doctors are operating their Medicare program without *any* formal fee schedule. Like their colleagues in the "maximum schedule" states, they're charging their usual fees. But unlike them, they're not having their fees compared with those listed on a negotiated "maximum schedule."

Why They Did It

What's behind this unique arrangement? Explains James W. Waggener, executive secretary of the Indiana association: "It is hoped we'll establish a precedent that will preclude physicians from being regimented under a rigid fee schedule in this and other government programs. . . . The Government is watching the Indiana experiment with interest. It has said to us:

"If you can prove [that] physicians can be allowed to set their individual fees without relation

to a fee schedule, and [if] the cost of operating the program on this basis is no more expensive than in other areas of like economic status where physicians operate under a schedule, then we will . . . consider relaxing our restrictions on other physicians throughout the country."

There are two controls on the Indiana experiment:

1. A state medical association board of review is studying all claims for payment. If the board believes a physician is trying to overcharge, it will ask him to substantiate his bill.

2. The Indiana association gave the Government an estimated fee schedule. It told the Government it believed that the average charges of Indiana doctors would not exceed these amounts when averaged out at the end of the year.

Doctors as well as Government officials will be watching the Indiana plan with interest. They'll also be comparing their own programs with others. And they'll be looking toward the future.

When Medicare schedules are renegotiated next July, fees could become more standardized. But to date, at least, the trend doesn't appear to be that way. END

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Can You Pass This Insurance Test?

If you get a perfect score, you really know how to buy insurance. But some of the right answers are almost certain to surprise you

By Michael H. Levy

What's the right way to buy insurance?

Over the years I've heard hundreds of people comment on that question. Following are some of the statements they've made. Which ones would you grade true, and which ones false?

Guard first against the probable loss. Decide which misfortunes are most likely to occur. Insure against them to the hilt. TRUE () FALSE ()

Buy the lowest-cost insurance you can find. Any group of policies is roughly the same in scope. A high premium just means big profits for the company.

TRUE () FALSE ()

THE AUTHOR heads a busy firm of insurance brokers (The Federated Brokerage Group, New York). But he's put himself repeatedly on the side of the premium-payer. This article approximates a portion of his remarkably frank book "Your Insurance and How to Profit By It," published by Harcourt, Brace and Company, New York.

Set aside a fixed percentage of your income for insurance premiums. In general, your coverage should be directly proportionate to your earning power.

TRUE () FALSE ()

Buy all the insurance you can get. Insurance is always a good investment, and you never know what'll happen.

TRUE () FALSE ()

Buy your insurance from as many brokers, agents, and companies as you can. That way, you get the benefit of many insurance advisers. TRUE () FALSE ()

All right, let's see what your score comes to:

"Guard first against the probable loss" should have been marked *False*. The probable loss will ordinarily irritate and annoy; the improbable loss may smash and paralyze. Here's a recent example:

Dr. B, a newly married man, worked out an insurance program for himself. There'd been a minor crime wave in his neighborhood, so he took out a big residence theft policy. As for steam boiler explosion insurance, he merely shook his head. "How often do things like that happen?" he said to himself.

Dr. B was right: Steam boilers rarely burst. But one did explode in his \$20,000 house about eight months later. Luckily, the family wasn't home when it happened, for one whole section of the house was blown to bits. Improbable, but it happened. Result: catastrophe.

"Buy the lowest-cost insurance you can find" should

CAN YOU PASS THIS INSURANCE TEST?

also have been marked *False*. With insurance, as with any other product, you tend to get what you pay for. Almost always, very low premiums mean either restricted coverage or a substandard company.

To illustrate, here's another sad but true story:

A Wisconsin man bought all his fire insurance through a local cooperative. He failed to check carefully enough into its financial statement. He knew only that he was saving \$38 a year in premiums.

Then a bad loss occurred. The cooperative didn't have the proper reinsurance agreement, and its resources were exhausted. The man was shocked to find that his loss wasn't paid and he was actually assessed! So his "economy" cost him about \$5,000 before he was through.

Cover Your Risks

"Set aside a fixed percentage of your income for insurance premiums"—that's also *False*. I don't know where this notion started, but it's not based on

New Name for It

A few years ago, when I was sharing a reception room with a urologist, a woman brought her gangling 14-year-old son into my office. "Doctor," she began, "it's his plunger. It's been all swollen up and red and hurting him for the last three days."

My nurse blushed. I started to tell the mother that she'd probably come in the wrong door, that she undoubtedly wanted the urologist, that my specialty was something entirely different—otolaryngology.

Then I noticed that the boy's mouth was half-open. On a hunch, I looked in. Sure enough, there was what his mother had called his "plunger": a very red and very swollen uvula.

—W. J. AAGESEN, M.D.

For each previously unpublished anecdote accepted, MEDICAL ECONOMICS pays \$25 to \$40. Address: Anecdotes, Medical Economics, Inc., Oradell, N.J.

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Riker LOS ANGELES

CAN YOU PASS THIS INSURANCE TEST?

logic. Your risks, not your income, should determine your insurance coverage. Look at it this way:

A newsboy slips and breaks his back on the sidewalk in front of a palatial forty-room house. The same newsboy slips and breaks his back in front of a cozy, five-room cottage. In *both* cases, the lawsuit is apt to be for \$100,000 or so.

"Buy all the insurance you can get" should be marked *False* too. Yes, we all know the fellow who buys every new gimmick-type coverage on the market. "Look at this swell plate-glass coverage for picture windows," he says, waving a beautifully engraved policy under your nose. "Boy, you'll be sorry you don't have this one the way I do."

Not Worth the Cost

And, sure enough, eight years later a youngster smacks a baseball into his living room and the insurance company cheerfully pays off to the tune of \$49.54. By this time, of course, he has contributed \$67.11 in premiums.

"Buy your insurance from as many brokers, agents, and companies as you can" is dangerously *False*. Never is the too-many-

cooks cliche truer than in the insurance field.

You may avoid friction and phone calls if you hand your insurance to every Tom, Dick, and Harry who asks for it. But you'll also put yourself in a highly perilous financial position. If no one insurance adviser is familiar with your total picture, many serious errors can result.

This point deserves two horrible examples:

Too Many Agents

1. Dr. P bought life insurance all over the map. Every time someone did him a favor, he reciprocated by buying insurance either from the person himself or from a friend or relative of the person. As a result, the doctor had a hodge-podge of coverage. It didn't properly cover his family's actual needs, even though he was spending about \$3,000 a year in premiums. And no agent knew the complete picture, for none had earned enough commission to make it worthwhile to analyze the doctor's entire insurance problem.

When Dr. P died, about one-third of his insurance was wasted in taxes.

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fellow in New York had eight men handling his insurance program —two for fire insurance, one for theft insurance, one for floaters, one for automobile insurance, and three for life insurance.

When the man's wife had a baby, a nurse was hired to care for it. According to New York State law, that nurse had to be covered under domestic compensation insurance. But not one of eight insurance advisers was concerned with this brand of coverage. So no one advised him to get what he actually needed.

What happened? A bottle

sterilizer exploded seven inches from the nurse's face. She was badly scalded. Not only was our friend legally responsible; he also had to pay a 100 per cent penalty under the New York State law.

The Positive Side

Now, what can we say positively about the *right* way to buy insurance? Well, I've already suggested three points by implication:

1. *Use insurance mainly to protect yourself against catastrophe.* Ask yourself what's the worst that can happen. Then insure yourself against it.

[MORE ▶]

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Massengill Powder solutions are a valuable adjunct in the management of monilia, trichomonas, staphylococcus, and streptococcus infections of the vaginal tract. Routine douching with Massengill Powder solution minimizes subjective discomfort and maintains a state of cleanliness and normal acidity without interfering with specific treatment.

*In a recent clinical report, ambulatory patients—with an alkaline vaginal mucosa resulting from pathogens—maintained an acid vaginal mucosa of pH 3.5 for 4 to 6 hours after douching with Massengill Powder; recumbent

patients maintained a satisfactory acid condition up to 24 hours.

*Arnot, F. H.: West. J. Surg., Obs., and Gyn. 62:85

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CAN YOU PASS THIS INSURANCE TEST?

2. Consider coverage first, premium second. Remember that cheap insurance can mean cheap protection.

3. Buy through a minimum of brokers or agents, in order to build an integrated, unified insurance program.

Now, to round out the picture, here are several other points worth considering, regardless of the type of coverage:

4. Read your policy. Seems obvious—but 99 per cent of all insurance buyers don't do it. Insurance contracts aren't packed with drama or suspense, but

they're far easier to understand than most people realize.

Watch out, in particular, for exclusions. The day of fine-print piracy is almost over, and most policies are now standardized both as to content and type size. But "most" isn't all. You can still lose your shirt via legalistic exclusions.

Sorry, No Pay

This is especially true in the health and accident field. As every doctor knows, you continue to find policies that pay off handsomely on "bubonic plague and



Diagrammatic illustration of an atherosclerotic artery, showing hemorrhage and the passage of lipid cholesterol plaques within the fibrous intima layer of the artery wall.

In two recent studies^{1,2} of a total of 86 subjects, the administration of niacin in high dosage (as provided by *Vastran Forte*) resulted in "significantly" reduced cholesterol levels in 81.4 per cent, and caused the pattern of blood lipids to "change toward normal." *Vastran Forte* also provides various factors of the B-complex to stimulate cellular metabolism.

1. Altshul, R., Hoff, A., and Stephen, J. D. *Arch. Biochem.* 54:558, 1955.

2. Parsons, W. B., Jr. et al. *Proc. Staff Meet. Mayo Clin.* 31:11, 1956.

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Asiatic cholera," but that exclude "diseases or disorders of the heart or circulatory system and pulmonary difficulties."

Especially for You

5. Keep an eye peeled for worthwhile insurance deals custom-made for you. In recent years, insurance firms have dreamed up dozens of special policies that are geared to save you both cash and grief.

The personal property floater is a good example. If you own a substantial store of worldly goods and haven't considered buying

this coverage, you ought to have your head—or your broker—examined.

6. Buy comprehensive coverage. Historically, insurance has gone in two directions. First there was the growth of specific policies—fire, life, accident, liability, and theft. In the last dozen years there's been a counter-trend: Two, five or twenty policies are now combined into one catch-all comprehensive contract.

Such comprehensive coverage often costs a little more. But it's nearly always worth it, because it includes important coverages

a safe, effective means of reducing high cholesterol levels

In each capsule:

Nicotinic acid 375.0 mg.

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you might not otherwise buy. For example:

In 1953, a freak tornado swept through Worcester, Mass. Nine out of ten people weren't covered, because "Tornadoes never hit New England." The tenth homeowner collected under his extended coverage. For pennies a day he had saved his home and his future.

How to Save 16%

7. *Buy on a budget plan.* Unless you dislike money, you should cut your premiums to the bone. This can be done by buying insurance for three, four, or five years instead of for just one.

Under the so-called "budget plan," three policies are issued, the first for a period of one year, the second for two years, and the third for three years. At expiration, the first policy is renewed for three years; a year later, so is the second policy; and so on. You ultimately get the benefit of the three-year rate, and each year you lay out one-third of the total three-year premium.

Your insurance broker or agent will explain this financial wizardry more fully. Through it, he may save you a whopping 16 per cent on your premiums.

8. *Buy deductible contracts.* They're far cheaper.

Tiny claims jack up insurance rates. A \$5 claim on a cigarette burn costs almost as much to settle as a \$5,000 jewelry theft. So the insurance companies have worked out "deductible clauses," which eliminate the small claim but still guard against the real major-league catastrophe.

With a \$50 deductible clause, for instance, you pay the first \$50 yourself. The insurance company pays the rest. And a fat 15 or 20 per cent is clipped off your annual premium costs.

Ask for Advice

9. *Get yourself a good broker or agent.* If you're willing to read a dozen books on insurance, and if you're ready to make more than a hundred contacts in the field, you may enjoy buying all your own coverage. Otherwise you'll need a competent adviser.

And make sure he is competent. Insurance brokerage is a profession. Select a top insurance specialist with the same care you use in selecting a medical specialist for your referrals. Think of your insurance man as the person who'll represent you *after* the tragedy. END

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Industry Offers You

EDITOR'S NOTE: As American industry has grown, so has industrial medicine. What's the field really like today? Is it worth going into part-time? Exactly how does a doctor go about getting into it?

Here's a three-part interview with a physician who has the answers. He's Jermyn F. McCahan, medical director of loss prevention medical service for the Liberty Mutual Insurance Co.

Dr. McCahan lectures on industrial medicine at Harvard, Boston University, and Tufts. He formerly served as the assistant secretary of the A.M.A.'s Council on Industrial Health.

The interviewer is Lois R. Chevalier, MEDICAL ECONOMICS' research director.



Part 1: Getting Started

- *The opportunities in part-time practice*
- *How to break into the industrial field*
- *How to figure how much time such work will take*

Q. Dr. McCahan, would you say the part-time opportunities in industrial medicine are greater than the full-time ones?

A. Much greater. It takes 2,000 to 2,500 employees

Part-Time Opportunities

before a plant needs a full-time physician. There are relatively few plants that big. In fact, nine out of ten plants employ less than 500.

I'd say that any industrial plant with seventy-five or a hundred employees could use a part-time doctor. So the part-time opportunities are considerably greater.

Q. By industrial plant do you mean factory?

A. Not quite. We don't think of industrial medicine as being limited to factories. Stores, hospitals, telephone companies, office buildings—all such places where people congregate to work are really parts of industry. On-the-premises medical service pays as great dividends there as in the manufacturing fields.

Q. Doctor, do you find any prejudice among physicians today against the industrial doctor—including the part-timer? I once knew a West Coast G.P. who used to visit a near-by city every afternoon to work part-time for the Southern Pacific railroad. But he did everything he possibly could to keep it a secret.

A. Well, I've heard of a doctor who did the same thing with a department store. He was the part-time physician there, and he almost used to sneak into the store. He was terribly embarrassed when a medical friend found out he worked there.

There've been many instances in the past of men going

into industrial practice and then being embarrassed by the prejudice against it. To some extent, that prejudice still exists.

Q. Why? Do people still think that a company doctor is someone who couldn't make the grade in private practice?

A. Well, that enters into it. There's also a feeling that he's selling his soul to management . . . taking sides with the employer against the employe . . . that kind of thing.

The Bad Old Days

I have little doubt that in the early days of industrial medicine, a number of company doctors were pretty slack and slapdash. The whole field got a bad name. That was from about 1911, when the first workmen's compensation laws were passed, up until the late Thirties.

Then industrial medicine really began to rise in status. And World War II greatly sped the process. Today, of course, it's a recognized specialty with its own certifying board.

Q. In setting up a medical service, does a company approach some doctor, or vice versa?

A. Usually the company will make the approach. But, unhap-

pily, company management doesn't always know the best way to go about it.

Q. How's that?

A. Well, it often looks for a physician doing such work for another plant and gets in touch with him. This may work out all right. But sometimes the plant manager asks his family physician, who may know little or nothing about industrial medicine, to recommend a plant doctor. As a result, the plant may take on a physician who's not really equipped to set up and administer the particular kind of service it needs.

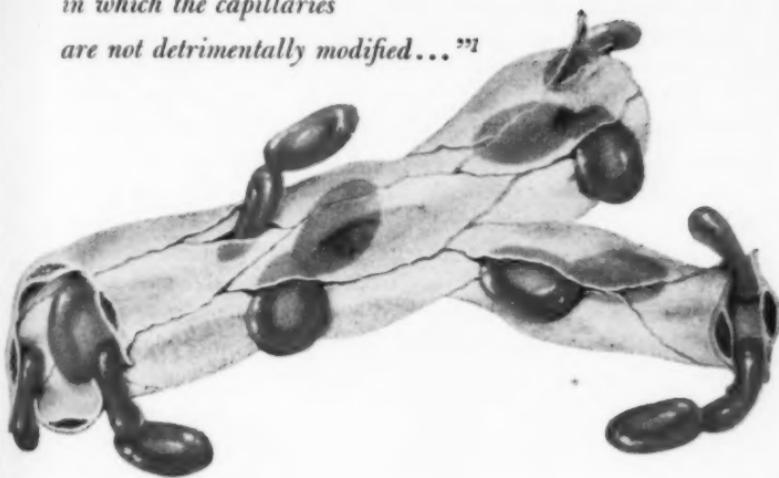
Management's best bet is to consult the industrial health committee of the local county or state medical society. They usually know of available physicians. (Any doctor interested in industrial medicine should of course be sure these committees have full details about him.)

How to Advertise

Q. How else may a doctor let it be known he's interested?

A. One good way is to talk on some phase of industrial medicine at a local chamber of commerce, Rotary Club, or management council meeting; such

...there is no diseased state
in which the capillaries
are not detrimentally modified..."



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References: 1. Martin, G. J., et al.: Exper. Med. & Surg. 12:535, 1954. 2. Griffith, J. Q., Jr., and Lindauer, M. A.: Am. Heart J. 28:758, 1944. 3. Barishaw, S. B.: Exper. Med. & Surg.: 7:358, 1949. 4. Epstein, E. Z., and Greenspan, E. B.: Arch. Int. Med. 68:1074, 1941. 5. Warter, P. J., et al.: Delaware M. J. 20:41, 1948. 6. Beaser, S. B., et al.: Arch. Int. Med. 73:18, 1944. 7. Greenblatt, R. B.: Office Endocrinology, ed. 4, Springfield, Ill., Charles C Thomas, 1952. 8. Gale, E. T., and Thewles, M. W.: Geriatrics 8:80, 1953. 9. Drezner, H. L., et al.: Am. Pract. & Digest. Treat. 6:912, 1955. 10. Selsman, G. J. V., and Horoschak, S.: Am. J. Digest Dis. 17:92, 1950. 11. Loughlin, W. C.: New York J. Med. 49:1823, 1949.

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PART-TIME INDUSTRIAL PRACTICE

groups welcome having a doctor tell them the advantages of in-plant medical programs. And his talk will help identify him as a man who's familiar with the subject.

Q. When first approached about such work, how can a doctor figure how much of his time a plant will need?

A. Here's a rule of thumb: If a plant has seventy-five employees, it can probably use one hour of

doctor time per week. It can also use one hour of nursing service per day.

This varies, of course, with the industry. If it has a lot of accidents and work tension, the plant may need much more doctor-nurse time. If the work presents no injury problems and if there's little personnel turnover and thus little new examining to do, the plant should need less time.

There's also the nature of the



"Of course I get up at night to urinate! How else?"

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presents
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...for the patient with seborrheic dermatitis of the scalp

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A. With them you can now produce any degree of effect from tranquilization, through sedation, to hypnosis.

Q. What are the indications?

A. Placidyl is indicated in cases of nervous or muscular tension, mild anxiety or excitement, and in simple insomnia resulting from these conditions.

Q. Does Placidyl provide muscle relaxation?

A. Yes, it possesses mild muscle relaxant properties which provide added advantage in tension states.

Q. Does Placidyl sedation hinder the patient's work?

A. No. Investigators have agreed that by selecting a suitable dose, tranquilization can be achieved without any confusion or loss of contact with surroundings.

Q. What daytime dosage is recommended?

A. Adult dose ranges from 100 mg., b.i.d., to 200 mg., t.i.d., depending on patient's condition and response.

Q. Are the new dosage sizes useful for insomnia, too?

A. Yes. 500 mg. remains the average hypnotic dose; but if your patient also is taking Placidyl by day, 100 or 200 mg. at bedtime is usually enough to stop insomnia.

Q. Is Placidyl sold under other trade names?

A. No. It is a mild, halogenated carbinol, structurally unique, made only by Abbott. Supplied in 100-mg., 200-mg., and 500-mg. capsules, bottles of 100.

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work force. If it's mostly older people or women, they'll need more service than a younger work force or one that's mostly men.

Take an electronics plant with younger men doing light work. There you'd need relatively few doctor-nurse hours.

Q. What about a heavy-machine industry with mostly men? Wouldn't there be a higher accident rate—and therefore a greater need for the doctor's time—than in a light industry where women predominate?

A. Usually that's not the case. Women employes have so many more illnesses and emotional upsets than men that the doctor almost always needs more time for a group of women than for a group of men.

Q. I suppose another important consideration is the location of the plant.

A. Yes. In some places, many community medical services are quickly available. In more isolated areas, the in-plant service may be all the local medical service there is.

None of these variables can rightly be disregarded in figuring how much of a doctor's time a plant will need. This time may amount to an hour a day for every fifty employes. Or it may be an hour a week for every 100 employes.

The best thing to do is to use the rule of thumb I mentioned—an hour per week per seventy-five employes—and then adjust it up or down.

Part 2: Income and Hours

- *How much you can expect to earn*
- *How to determine your proper fees*
- *How to arrange your hours at the plant*

Q. Dr. McCahan, do you think that part-time industrial practice is financially worth-while for the average physician?

A. Absolutely. For one thing,

the income he earns through industrial practice is pretty much *net* income. He has no overhead. And he has no collection problems.

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PART-TIME INDUSTRIAL PRACTICE

Now, the average physician in private practice works about 60 hours a week. If he had a net income of \$8 an hour, that would be—let's see—\$480 a week, or about \$25,000 a year. Of course he doesn't net anywhere near that. The median, as your magazine reported last October, is around \$16,000.

Yet the median rate in part-time industrial practice is \$8 an hour. This certainly compares well with most doctors' hourly net earnings.

Q. Is payment at an hourly rate the best arrangement?

A. Well, there's one advantage for both doctor and employer in the hourly rate: If the employer needs more service or less than expected, the doctor is paid in direct proportion.

Generally, I think the doctor should be on an hourly rate if he gives less than three hours' service a day. If he works *more* than three hours a day, he probably should go on an annual retainer.

Q. What, exactly, does the annual retainer cover?

A. The retainer should cover only his in-plant service. But sometimes it covers both in-plant

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and office service—which means that if an employe is injured and sent to the doctor's office, the doctor gets no extra fee. This can be bad if the doctor misjudges how many office cases he'll get. They may interfere with his regular practice without producing proper returns.

Such a retainer may also be unfair to the company. Management may find it's paying for services the doctor hasn't given. So it's better that any retainer cover only in-plant services.

Q. Should whatever arrangement is made be put in writing?

A. That's been discussed widely, but it's still a moot question. In my opinion, a gentlemen's agreement is all that's necessary. I know of very, very few instances of such an agreement being broken.

Q. How does the doctor decide on the proper amount for an annual retainer?

A. I think the most sensible way is on the basis of a fair hourly fee for the number of hours he expects to work. I can't see any other logical way of deciding it.

Q. When the doctor is on an annual retainer, does the com-



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1. Rice, W. B., and McColl, J. D.: *J. Am. Pharm. A.* 45:137 (Mar.) 1956.

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PART-TIME INDUSTRIAL PRACTICE

pany put him on its regular payroll as a part-time employe?

A. Not necessarily. But the doctor may prefer to be there and may say so. Then he's covered by Social Security and can, in some cases, share in the plant's health and welfare benefits.

The On-Call Doctor

Q. Does the plant's size have much to do with the best sort of arrangement to make?

A. Yes. In plants with 100 employees or fewer, it's probably not worth-while for a doctor to go to the plant very often. But there's still the opportunity to be an on-call physician. As such, the doctor can examine employees in his office—both when they're hired and at intervals later.

First, of course, he'll have to go to the plant to find out what work is performed there and what hazards exist. These will determine the type of physical examinations he'll perform.

The on-call physician is also expected to help management set up a first-aid program and train workers to give emergency care.

Q. On what basis is the on-call doctor paid?

A. Usually he gets a certain fee per plant visit and a certain fee per

physical examination. Amounts depend on going rates in the particular area.

Q. What about fees the part-time industrial doctor would ordinarily receive for workmen's compensation cases?

A. Such cases as he treats at the plant are covered by his regular company pay. But for those he handles at his office or at the hospital, he should be paid extra, according to the workmen's compensation fee schedule.

Q. Isn't it usually preferable for the doctor to give examinations and treatments at the plant instead of at his office?

Doctor in the Plant

A. Yes—for two reasons. One is that the less time the employe is away from his job, the better.

The other reason is that the doctor can be medically more effective at the plant. If the patient has a job-connected health problem, the doctor can step right into the working area and see what work the employe does and under what conditions. This way, he can quickly find out if a work adjustment is necessary.

Suppose the employe has a skin irritation caused by putting his hands in oil. If the doctor saw

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him at his office, he might treat him and send him back to his regular job. Or he might tell him he couldn't work at that job any longer.

But if the doctor sees the patient in the plant medical department, he can go with him to his work bench to learn exactly how the employe has been getting into trouble. The doctor may be able to point out that if the man could change his work methods, he wouldn't have to put his hands in the oil so much.

Q. How does a doctor decide the best time to make his plant visits?

A. The important thing is to visit the plant on a regular schedule. And, of course, his visits

should be at hours when most employes can consult him.

In a plant with two shifts, he might come late in the afternoon. Then he could see the first shift as they were ready to go home, the second shift as they were coming on.

A bakery, on the other hand, may have drivers who start their routes at dawn, are out all morning, then come in around noon to end their day. Noon would then be the best time for the doctor's visits—the only time, in fact, when all the employes could be expected to be present.

The doctor must consider all such variables. They're important in deciding how his time and services should be planned.

Part 3: Doing the Job

- *How to find out what you need to know*
- *How to get along with management*
- *How to avoid friction with foremen*

Q. Dr. McCahan, you spoke earlier of the doctor inspecting the plant to see what health hazards various workers might encounter. Can you explain this more specifically?

A. Well, suppose it's a foundry. The doctor gets a slip saying the man he's about to examine is being hired to do shake-out, or molding, or sandblasting. If the doctor hasn't visited the foundry,

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1. Nelson, R. O.: Ohio State M.J. (in press).

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he may not have the foggiest notion of what a shake-out man or a molder or a sandblaster does.

But if he's been to the plant and knows, he'll say to himself: "So this fellow is going to do molding. That calls for plenty of all-around strength, including an extra-strong back. If he isn't the type, he shouldn't be placed on the job."

Where to Get Info

Q. Is there any central source from which a physician can get information about the health hazards in various industries?

A. There certainly is. The A.M.A.'s Council on Industrial Health, the Industrial Medical Association, the American Academy of Occupational Medicine, the divisions of industrial hygiene of the various state agencies, the Department of Occupational Health of the Public Health Service, and the major casualty insurance companies—all these are such sources. From them the doctor can get general information on almost any aspect of industrial medicine.

But for *specific* information, he first needs to ask the plant management exactly what tools and materials its workers use.

With that knowledge, he can go to the sources mentioned; and they'll either give him the information or tell him where to get it.

Q. How about asking doctors already in the field?

A. By all means. Even if the closest industrial doctor is miles away, the new man can profitably visit him. Industrial doctors are delighted to have such visits. They'd be happy to have more of them.

Other good sources of information are medical society committees on industrial health. Most state and many county governments also have industrial health committees.

How to Make Friends

Q. What about some advice on personnel relations? If the doctor is going to suggest changes in work methods and such, won't he have to be something of a diplomat?

A. Yes, indeed. Unless he's on good terms with the supervisors, his suggestions may be received less than cordially. He needs to make himself known to the supervisors beforehand. And they need to know that he'll come around occasionally to discuss working conditions with them.

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and with their fellow employees.

Whenever he talks to a supervisor, he must give the impression of an insider trying to help—not of an outsider trying to dictate. "I think if Joe could have a slight change in his work, he could stay on the job," the doctor may say. "Would he be any help to you doing something else, or handling his job in some modified way?"

The foreman then won't feel his authority is being usurped. Instead, he'll feel the doctor wants him to use his authority to make the job adjustment.

Q. Suppose when he's taking his first tour of the plant, the doctor sees things that seem dangerous or unhealthful. How should he suggest changes?

Be Careful With the Boss

A. He should hold his counsel long enough to make sure he's right (it's ruinous to tell management that something is wrong when it isn't). And, if possible, he should wait until he has created a receptive atmosphere. Management will respect his advice in direct ratio to its confidence in him—and this takes a while to develop.

Q. After confidence is estab-

lished, how should he approach management about a plant problem?

A. He may say: "By the way, have you noticed . . . ?" Or "What do you think about this situation . . . ?" He can sense immediately whether the company has already considered his idea and whether it's favorably or unfavorably inclined toward it.

Q. In other words, he should handle management somewhat as he handles his patients?

Do-It-or-Else Won't Do

A. Exactly. If a doctor uses a do-it-or-else line, the patient won't respond nearly so well as if the doctor tells him the facts, advises him what he thinks is best, and induces the patient to want to cooperate. It's the same with management.

More than one company has discontinued its medical service just because it got into a squabble with the doctor. Almost always, the doctor can avert this sort of thing.

Q. What are some typical squabbles the doctor should guard against?

A. Well, a typical one occurs when the heads of a company get the idea that the doctor thinks he

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Schwartz, E., New York J. Med. 56:570, 1956.

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PART-TIME INDUSTRIAL PRACTICE

knows more about their problems than they do.

Suppose in a particular plant there's relatively little danger of lung disease. Yet the doctor recommends a chest X-ray on every employe once a year. Management likes the idea but says it's not feasible right now.

Suppose, then, the doctor decides that if the employes can't have chest X-rays at once, his program is ruined. He argues with the management men in that vein. They get their fur up and say: "All right, if that's the way you see it, let's not have *any* program." Such things can happen.

Q. Isn't there labor union opposition to some health programs?

A. Most unions used to oppose pre-employment examinations; some still do. And often unions are against examinations *after* a man has been hired. They feel the employer may use the information later as an excuse to fire the employe. But unions usually accept examinations when they're satisfied the doctor will observe the recognized ethics of keeping the medical information confidential. Confidential, that is, unless the employe's condition endangers others. Even then, before going to management with the

information, the doctor should at least try to get the employe's permission to do so—preferably in writing. The employe will almost never object.

Q. What other situations can lead the doctor into trouble?

A. Well, there's one common in delivery services and in department stores during rush seasons. The doctor may think that every employe should be examined before being hired. But because of the nature of the business, this may not always be practicable. Management may have to hire some people first and have them examined later.

Obviously, the doctor should be ready to compromise things that are desirable or even necessary, but not actually *vital*.

Q. What if he's in a plant where quite a few of the employes may get silicosis unless management takes certain action that it evidently doesn't want to take?

A. The doctor will then have to roll up his sleeves and fight for what he knows is right, even at the risk of losing his job. The thing that's important to decide in any such situation is what can properly be compromised and what can't be. END

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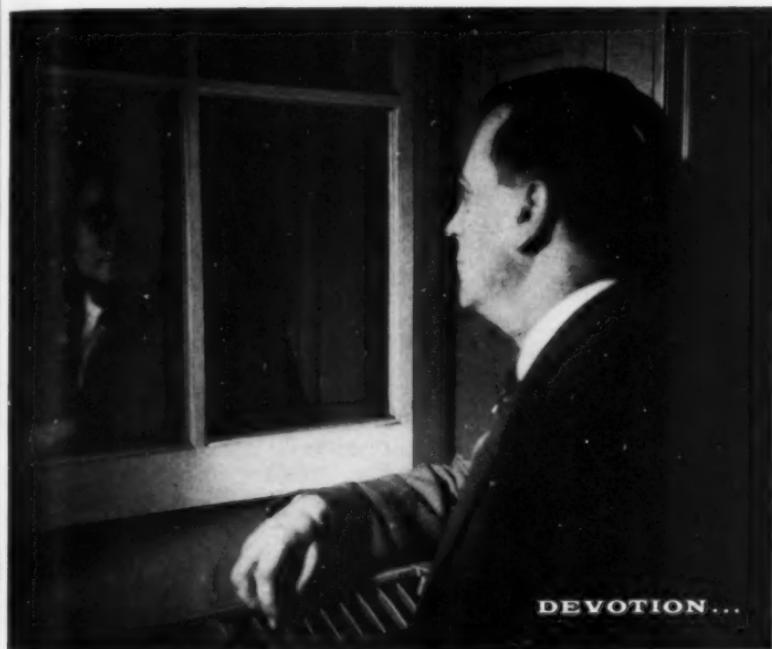
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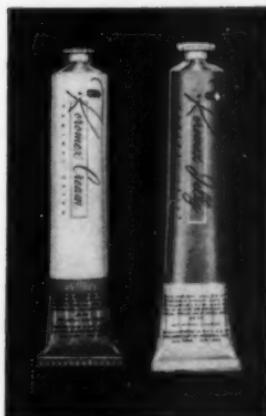
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Are Your Hospital Rights Well Protected?

[CONTINUED FROM 133]

the three main factions: the clinic specialists, the solo specialists, and the G.P.s. As you might guess, the privileges of the solo specialists were soon restored.

This illustrates a second characteristic of the well-organized joint conference committee: Its medical members are elected, not appointed. If, instead, the trustees appoint the medical members, here's the sort of thing that sometimes happens:

They Had No Evidence

In one of the Rocky Mountain states, a joint conference committee recommended that a certain general practitioner's privileges be cut down to almost nothing. The board of trustees accepted the recommendation. But the G.P. threatened to fight for his rights in court.

Alarmed, the trustees called me in. They'd been assured by the five doctors on the joint conference committee that the physician in question wasn't competent to perform surgery. But they had no evidence to back it up.

The hospital had no tissue committee, no medical audit committee.

"How can you be sure you're right in restricting this man's privileges?" I asked.

"Well, the joint conference committee recommended it," the trustees replied.

"Still, under the circumstances, it *could* be a pretty arbitrary recommendation. Suppose I study some of the medical records."

The records showed nothing against the accused general practitioner. So I suggested that a medical audit be made. On the audit, too, he came out fine. His surgery looked every bit as competent as that of the hospital's board-certified surgeon.

The explanation for his restriction? It turned out to be this:

Pro-Specialist Committee

The trustees had appointed the doctors they knew best as medical members of the joint conference committee. And the doctors they knew best were board-certified men who were jealous of their prerogatives. The G.P. was actually being "punished" for his competence. But none of the colleagues who would

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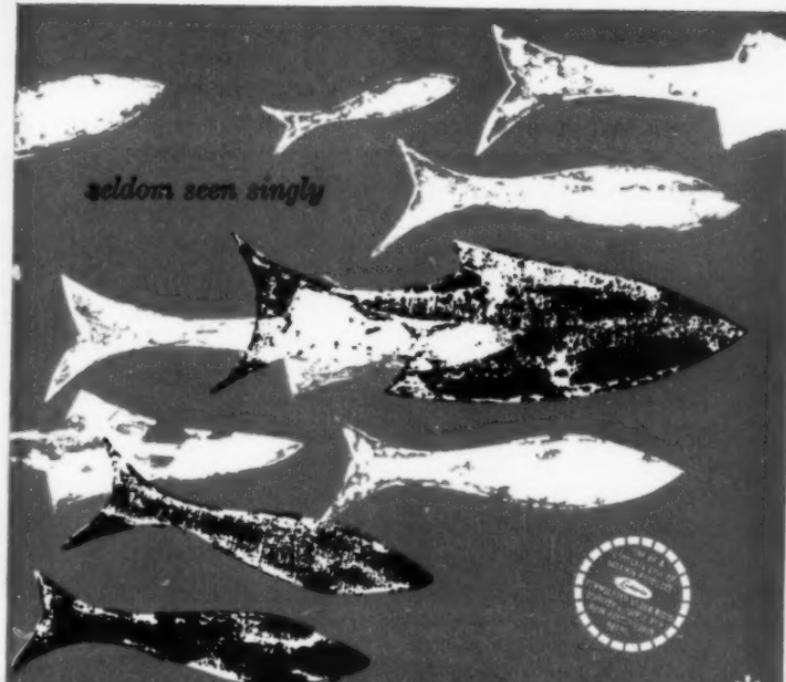
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YOUR HOSPITAL RIGHTS

have seen the situation from his point of view were on the trustee-chosen conference committee.

So the doctor-members of any joint conference committee should always be elected; and they should be elected in such a way as to guarantee representation of all factions. The ideal committee, I'd say, is composed of from three to five doctors, plus an equal number of trustees. The hospital administrator also attends its meetings, as a rule—but primarily as an observer.

The committee may discuss any or all of the hospital's poli-

cies. And the individual doctor can be sure it will protect his rights effectively, for the following very good reasons:

1. *It's a deliberative rather than an executive or administrative body.* It never passes on a recommendation to the board of trustees until all its members are in agreement. Sometimes, as a result, a particular problem may remain unsolved for months. But the benefits of deliberating until all members concur outweigh the drawbacks by a goodly margin.

A couple of years ago, for example, the specialists affiliated



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YOUR HOSPITAL RIGHTS

with a certain hospital in a major oil-producing area ganged up on their G.P. colleagues. In a rowdy medical staff meeting, the specialists pushed through a motion that only board-certified physicians could henceforth perform surgery.

The G.P.s Got Mad

By the time I arrived on the scene, everyone was pretty upset. In fact, the G.P.s were so angry they'd begun taking their patients to another hospital twenty miles away. Naturally, the patients weren't at all happy; nor—to tell the truth—were the specialists who'd caused the ruction.

So I helped set up a joint conference committee. And, as its first job, the committee tackled

the ticklish subject of G.P.-specialist relations. Sure, tempers flared. But no hot-headed measures could be taken by the committee, since neither side could outvote the other. By its very definition, the conference committee was obliged to *confer*—to discuss, to think, not to act hastily.

As a result, the men eventually hit on a formula that satisfied everybody. Each G.P. would list the procedures he felt qualified to do. Each list would be checked by a credentials committee. If it denied an individual G.P. any of the privileges he wanted, he could appeal to the joint conference committee.

How It Worked Out

Most of the G.P.s got the privileges they sought. Those that didn't got a chance to argue their case before any action was taken.

2. *Its deliberations are confidential.* Board of trustee meetings are sometimes open to the press. Even when they're not, the reasons for the board's decisions frequently become common knowledge.

In the typical joint conference committee, on the other hand, members are sworn to secrecy



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can do more *to bring*

**sustained
comfort
to your
anorectal
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than**



- soothes •
- protects •
- lubricates •
- eases pain •
- relieves itching •
- decongests •

DESITIN®

hemorrhoidal
SUPPOSITORIES
with cod liver oil

DESITIN SUPPOSITORIES afford rapid relief in hemorrhoids (non-surgical). Norwegian cod liver oil (rich in vitamins A and D and unsaturated fatty acids) helps promote healing. They do not contain styptics, local anesthetics, or narcotics and therefore do not mask serious rectal disease.

In boxes of 12.



samples are available from
DESITIN CHEMICAL COMPANY

Providence, R. I.

YOUR HOSPITAL RIGHTS

and no votes are recorded. Many times, no minutes are kept. As a result, both trustees and doctors can let their hair down.

No One's the Wiser

This arrangement prevents outsiders from knowing why a certain doctor has lost some of his privileges or has been dropped from the staff. It also permits the committee to recommend such action when it might otherwise be difficult.

Not long ago, in one hospital I know of, the credentials committee recommended that a certain

G.P.'s privileges be withdrawn. It refused to give a reason for its recommendation. So the G.P. appealed to the joint conference committee.

That body soon learned that the G.P. had become addicted to drugs. So it did more than ask that his privileges be withdrawn; it recommended he be dropped from the staff. Because its deliberations were secret, however, the doctor was never exposed to public shame.

3. *It protects doctors from losing their rights merely because of personal spite.* For instance:

2028 M. ADLON, M.D.
7 Lenox Place, Brooklyn, N.Y.

PATIENT *Robert B. Baker*

R

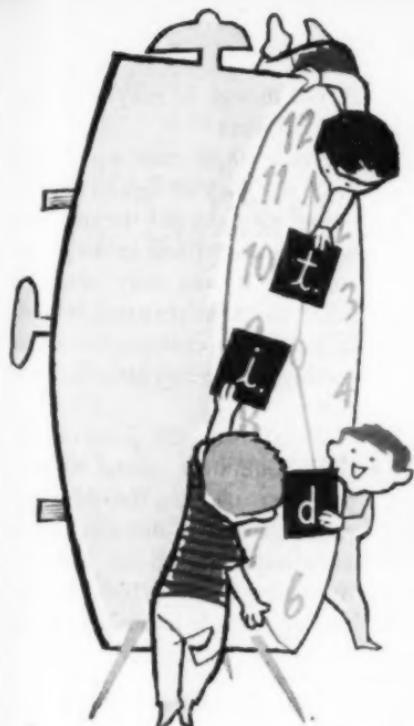
MAGNACORT* *3 1/2*
ethamicort

Sig. apply locally b.i.d.

Robert B. Baker
M.D.

*trademark

PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York



One dose
goes a
long way

TUSSAR

the long acting
cough syrup

provides greater relief with fewer doses per day

One teaspoonful t.i.d. or q.i.d. provides 24-hour control of even obstinate, hacking coughs.

Each fluid ounce of Tussar contains:

Dihydrocodeinone bitartrate.....	1/6 gr.
(may be habit forming)	
Prophenpyridamine maleate.....	1 gr.
Potassium guaiacol sulfonate, N.F.	8 gr.
Sodium citrate, U.S.P.	13.2 gr.
Citric acid, U.S.P.	2 gr.
Chloroform, U.S.P.	2 minimis
Methylparaben, U.S.P.	0.1%
Flavor, sweetening, aroma, vehicle	

Ammonium chloride, potassium iodide or ephedrine may be added to Tussar.



THE ARMOUR LABORATORIES

A DIVISION OF ARMOUR AND COMPANY • KANKAKEE, ILLINOIS

A young plastic surgeon who'd developed a hatred of his old chief began making casual remarks implying that the chief's age was starting to tell on his work. "That last operation the chief did—not very good," he'd say to his colleagues. "The patient might sue. We might all have to pay."

A Speech in Time

Only a few months of such talk did the trick: Unaware of the young surgeon's personal grudge, several practitioners on the joint conference committee brought up the possibility of limiting the older man's privileges. Fortunately, the hospital administrator intervened. "I think the world of Dr. R and his work," he said. "Before we do anything, let's get the opinion of an outside observer."

I was asked to visit the hospital. It didn't take long for an outsider like me to discover that the only evidence against the man was hearsay—and that all of it stemmed from the younger surgeon. So I brought a number of the staff doctors together.

"Gentlemen," I said, "is there anyone here who'd be willing to testify in a court of law that Dr.

R, old though he may be, is doing bad work?"

Not a single man was willing to do so. They all agreed that the young surgeon was the only one who knew anything about plastic surgery. It was only after I'd pointed out the personal animosity behind his criticisms that they realized how badly he'd deceived them.

As a result, the joint conference committee tabled its proposal for revoking the older surgeon's privileges. But what would have happened if, for instance, the young surgeon had been his colleagues' sole representative on the board of trustees?

Why It's the Best

You may think such a man could never be chosen a trustee. And you may be right. You may also believe that *any* system of doctor-trustee liaison will be effective provided there's goodwill on both sides. Again you may be right.

But as a general rule, I've found, it's the joint conference committee that *fosters* goodwill. Such a committee makes it certain that the will of each doctor on the hospital staff gets a full, fair hearing.

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in a single tablet -

pain relief

plus

antibacterial action

AZO GANTRISIN

In urinary tract infections, Azo Gantrisin usually provides effective antibacterial control (local and systemic), together with prompt relief of associated pain and discomfort . . . by combining well-tolerated Gantrisin with a clinically proved urinary analgesic.



Each Azo Gantrisin tablet contains 0.5 Gm Gantrisin 'Roche' plus 50 mg phenylazo-diamino-pyridine HCl.

Gantrisin® - brand of sulfisoxazole

For the patient who just needs relaxation —

(not a personality change)

Noludar is a pharmacologically simple drug — a CNS sedative and nothing else — a piperidine derivative, not a barbiturate. Fifty mg t.i.d. provides daytime sedation without undue drowsiness, while 200-400 mg h.s. induces a restful night's sleep, usually without hangover.

Hoffmann-La Roche Inc, Nutley, N.J.

Noludar® — brand of methyprylon

Doctors
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XUM

The new Comptometer® Commander

"Makes Dictation Easy as Talking
to an Old Friend"



All controls are in the
palm of your hand...
with UNIMATIC
REMOTE CONTROL
MICROPHONE



- Dictate
- Listen
- Unlimited Review
- Erase unwanted words
- Mark end of letter... electronically
- Use same machine for dictation, transcription
- Lifetime belt—never wears out

Try it FREE in your office

Doctors tell us, "At last I'm free of the bothersome mechanics of dictation." Reason is, you never touch the Comptometer COMMANDER. Reports, forms, case histories, letters, are handled as easily as talking to an old friend, because ALL controls are in the palm of your hand with UNIMATIC remote control microphone. The same machine serves as a transcriber... for it's as easy to transcribe as to listen, because, with perfect dictation, there's no need

for time-wasting, error-breeding pre-editing. Best of all, the Comptometer COMMANDER actually pays for itself over and over. The mailable Lifetime guaranteed Erase-O-Matic belt wipes clean, electronically, in a second, ready for re-use thousands of times. No recurring cost for belts, discs, or cylinders.

Learn how easy dictation can be—how anyone can turn out a greater volume of perfect letters easier, faster! Want proof? Mail the coupon!

Comptometer - BETTER PRODUCTS TO BETTER BUSINESS



COMPTOMETER—World's fastest way
to figure. Try it FREE on your work in
your office. Use coupon.



Comptometer COMPTOGRAPH '202'
No hand motion. More fine features
than any other 10-key machine.
Try it FREE—use coupon.

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Ltd. 501 Yonge St., Toronto 5, Can.

Arrange a FREE office trial for me on:
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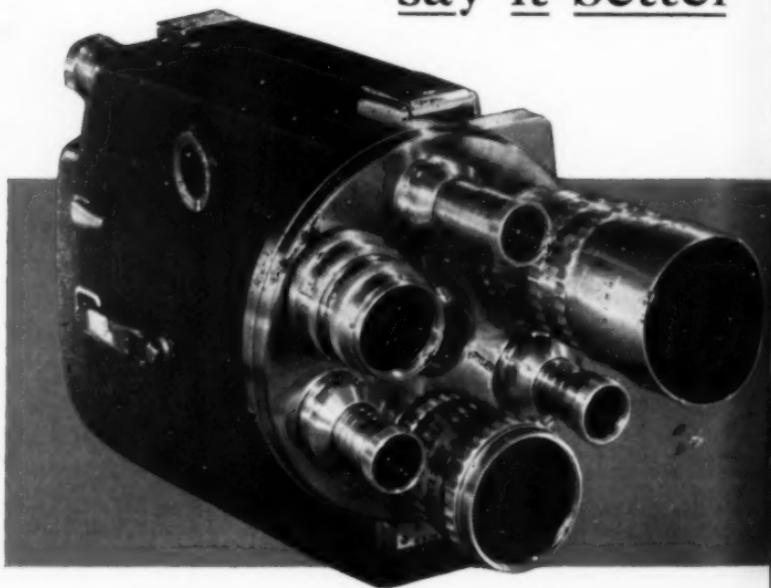
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Firm _____

Address _____

City _____ Zone _____ State _____

Pictures
help you
say it better



Get better pictures with
... the Cine-Kodak

WITH this truly great Cine-Kodak camera you can keep a photographic record of all your significant cases... have 16mm movies—color or black-and-white—for review and discussion. It accepts any of three fine Kodak Cine Ektar Lenses—15mm to 152mm... has matching view-finders. The drive mechanism—a powerful, prestressed

Serving medical progress through Photography and Radiography

motor
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See
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Medic



Photograph: David Lubin, Medical Illustration Service, U.S.V.A. Hospital, Cleveland 30, Ohio

Kodak K-100 Turret Camera

motor—pulls 40 feet of film through at a single winding . . . assures exact uniformity at every operating speed. Quick, easy loading. Simple, positive operation. Camera is priced from \$315 (single-lens model from \$279).

See your Kodak photographic dealer, or write for details.

Prices include Federal Tax where applicable and are subject to change without notice.

EASTMAN KODAK COMPANY

Medical Division • Rochester 4, N. Y.

Kodak

TRADE MARK

How to Save Some Money for Your Heirs

[CONTINUED FROM 111]

and thus from your estate. Even though such a trust may bring on gift taxes, these are much lower than estate taxes.

Putting all property in trust saves administration costs at the deaths of both you and your wife. This helps explain the minimum shrinkage shown.

Other Methods

Special tax savings are possible when you own large life insurance policies. Say, for example, you have assets of \$200,000 plus a \$100,000 policy. At your death, insurance proceeds are ordinarily added to other assets in determining your total estate.

But suppose that, while living,

you transfer ownership of this policy to your wife (or to a trust for the benefit of your family). Since you then no longer own the policy, its value is not added to that of your estate at death. By thus drastically reducing the size of your taxable estate, you cut taxes sharply—in this case by almost 50 per cent of what they'd otherwise have been.*

The transfer methods illustrated in this article emphasize only the tax-saving aspect of proper estate planning. Obviously, your purpose in planning isn't merely to cut taxes to the bone. You may prefer a transfer method that, while costing more in taxes, gives you greater use of your assets while you're alive. END

*For a more detailed discussion of the estate tax advantages of transferring ownership of policies, see "Who Should Own Your Life Insurance Policy?" MEDICAL ECONOMICS, May, 1955.

Rx for Bedsores

I was accompanying a G.P.-colleague on house calls. We stopped in to see a beauteous young patient whose profession was the world's oldest.

After examining her for lower abdominal pain, my colleague gave her an injection of penicillin. "Now," he said, "I want you to stay OUT of bed for a few days."

—JORDAN A. SESKIND, M.D.

Controls nervousness and tension in the older patient

With 'Compazine', agitated senile patients become calmer and more cooperative, and often take a new interest in their homes and families.

Vischer¹ treated a 76-year-old woman for extreme nervousness and tremors. He found that "After less than three weeks treatment with proclorperazine ['Compazine'], 15 mg. daily, she no longer had any tremors, was substantially less nervous and reported: 'Doctor, I feel like doing and going.'"

'Compazine' is rapid-acting, highly effective and has shown minimal side effects.

Available: 5 mg. tablets in bottles of 50.

Compazine[®]

a true tranquilizing agent

Smith, Kline & French Laboratories, Philadelphia

1. Vischer, T.J.: *Unpublished data from Clinical Study of Proclorperazine, a New Tranquilizer for the Treatment of Non-Hospitalized Psychoneurotic Patients.*

^{*}Trademark for proclorperazine, S.K.F.

Yardsticks For Your Practice

[CONTINUED FROM 115]

nial Survey, like earlier ones, was planned and executed by its editors. Questionnaires went out last April to every fourth name on the M.D. mailing list—a total of almost 35,000 physicians in active practice. Excluded from the survey group were internes, residents, retired physicians, and doctors in full-time government service.

Exactly 10,919 M.D.s took the trouble to fill out the time-consuming questionnaire. This response of 31 per cent on one mailing has never been equaled by any such study in the past.



Columbia University's Bureau of Applied Social Research did the tabulating. Since there were many more returns than needed for a statistically adequate sample, the Bureau used a free hand in discarding incomplete or questionable returns. Others were eliminated to make the sample a near-perfect cross-section.

After these adjustments, the basic sample consisted of 5,178 questionnaires.* It faithfully reflects the actual distribution of doctors among general practice and the major specialties, as shown in the 1955 edition of the American Medical Directory. In addition, the basic sample reflects the known distribution of doctors by years in practice, region, and community size.

In short, it's as representative a cross-section as you can find. And the figures drawn from it are as accurate as the conscientious efforts of doctors, editors, and statisticians can make them.

The doctors deserve your special thanks. They've performed a real service for the profession at large.

END

* Two supplemental samples were drawn from the surplus questionnaires for use where indicated. One represents the lesser specialties in greater numbers than in the basic sample. The other represents salaried doctors—meaning those who derive more than half their net earnings from salaries.

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INCREMIN*

LYSINE-VITAMIN SUPPLEMENT LEDERLE

outstanding
appetite
stimulant in

NEW TABLET FORM



Specify INCREMIN TABLETS to stimulate appetite in your problem-eater, underweight, or generally below-par patients of all ages.

INCREMIN TABLETS are highly palatable, caramel flavored. May be orally dissolved, chewed, or swallowed. Dosage only 1 tablet daily.

Each INCREMIN
TABLET contains:

1-Lysine	300 mg.
Vitamin B ₁₂	25 mcgm.
Thiamine (B ₁)	10 mg.
Pyridoxine (B ₆)	5 mg.

(INCREMIN Drops contain 1% alcohol)

Remember INCREMIN DROPS. Cherry flavor. Can be mixed with milk, milk formula, or other liquid. In 15 cc. polyethylene dropper bottle. Dosage: 0.5 to 1 cc. (10-20 drops) daily.



LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY
PEARL RIVER, NEW YORK

*Reg. U. S. Pat. Off.

IN e-yyS

[MORE NEWS ON PAGE 14]

Semantic Malpractice Draws Hawley's Ire

Doctors are just about the world's worst writers, according to Dr. Paul R. Hawley, director of the American College of Surgeons. "With few exceptions," he says, "the worst writing I have ever encountered has been in medical publications."

This is a new target for Dr. Hawley. But he fires away at it with the vigor and vitriol he has hitherto reserved for fee splitters. Too many medical reputations, he says, have been "based upon quantity of writing [rather than] upon quality. . . . Too many medical men rush into print with a sorry dish of warmed-over tripe. . . . Much of it has. . . . nothing new to say."

Even when a medical paper *does* have something to say, "acts of semantic malpractice" often make it suspect. Dr. Hawley says "use of bad grammar by a presumably educated person always raises doubt as to his professional competence."

He especially protests "the de-

plorable practice of using nouns as verbs. . . for example, 'cystoscopying a patient' and 'operating a case.'"

Such abuses, he believes, are more than ungrammatical; they're unscientific. "Precision is the most important requirement of scientific writing," he says. "Looseness of expression, with its danger of misinterpretation, is intolerable."

Dr. Hawley concludes with a personal opinion—"heresy," he calls it: "Ninety per cent of the medical literature of today could be dispensed with. . . this would increase, rather than diminish, the dissemination of medical knowledge."

How the Sears-Roebuck Fund Helps M.D.s

A year ago, the Sears-Roebuck Foundation offered to help doctors build facilities in towns that badly needed them. Today, as a result, the foundation has \$261,000 out on loan to doctors. And already, says a foundation spokesman, this investment "has created \$935,000

Gantrisin plus penicillin

Gantricillin is Gantrisin plus penicillin in a single tablet. For severe infections, Gantricillin-300; for mild infections, Gantricillin (100); for pediatric infections, Gantricillin (acetyl)-200 suspension.

Gantricillin® Gantrisin® brand of sulfisoxazole

in
a single
tablet

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roche

original research in medicine and chemistry



SEPTISOL

with HEXACHLOROPHENONE 0.75%

ANTISEPTIC LIQUID SOAP

Daily hand washing with SEPTISOL forms an invisible but protective film on the skin. For SEPTISOL contains the antiseptic agent, HEXACHLOROPHENONE, which remains on the skin after the hands are rinsed and dried. This antiseptic film provides a continuous barrier to infection and disease transmission with complete skin safety.



NEWS

in improved medical facilities, or roughly \$4 for every \$1 spent."

The foundation offers ten-year loans without security to doctors who want to begin or expand their practices. Grants are made on the basis of the community's need for improved medical facilities. Doctors are eligible only if all other loan sources have failed them. The maximum loan is \$25,000.

Repayment begins in the fourth year. Interest is charged only during the first three years; but thereafter the recipient pledges to contribute to the fund an amount roughly equivalent to what he would otherwise have paid in interest.

Hobbies Are This Doctor's Hobby

Want to start a new hobby? You should be able to get more practical suggestions from Dr. Clarence L. Laws than from almost any other physician in the country. This Atlanta, Ga., allergist has taken up five different hobbies and reaped a harvest of satisfaction from them.

Back in 1932, when he was a fellow at Boston's Peter Bent Brigham Hospital, one of his medical superiors presented him with several thousand stamps. Ever since, Dr. Laws has been an avid collector of U.S. mint stamps.

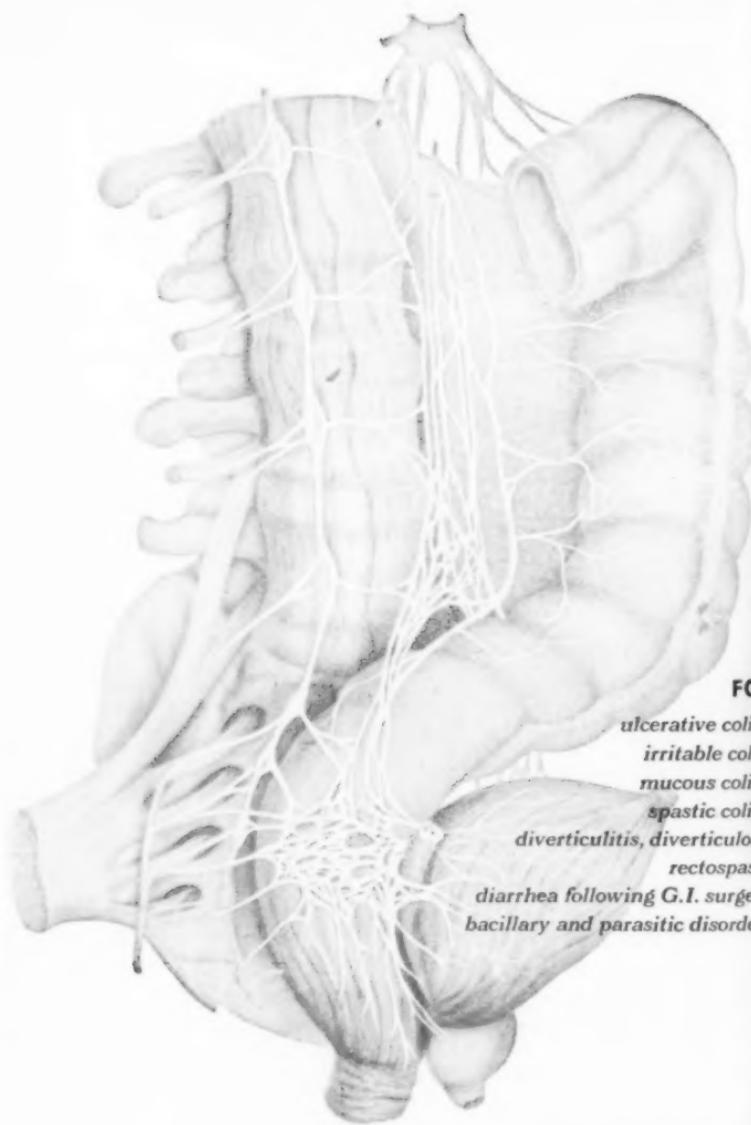
In 1940 he set up a woodworking shop in his basement and began making reproductions of Hepplewhite and Chippendale furniture. During the next seven years, he

a
new
chapter
in
surface
anesthesia

Tronothane®

(Pramoxine, Abbott)

Puts safety first.
Proved in 15,600
clinically-studied cases. Abbott



FOR

*ulcerative colitis
irritable colon
mucous colitis
spastic colitis
diverticulitis, diverticulosis
rectospasm
diarrhea following G.I. surgery
bacillary and parasitic disorders*

*For more detailed information, request Brochure No. NDA 16,
Lakeside Laboratories, Milwaukee 1, Wisconsin.*

announcing

for the colon

EFFECTIVE

relieves pain, cramps, bloating
curbs diarrhea
helps restore normal tone and motility

SELECTIVE

avoids widespread autonomic disturbance
unusually free of "antispasmodic" side effects
avoids urinary retention

HOW CANTIL BENEFITS COLON PATIENTS

CANTIL has a markedly selective anticholinergic action on the colon with little or no effect on stomach, small intestine and bladder.
In clinical studies 3 out of 4 patients obtained relief of symptoms and less than 10 per cent had any significant side effects.

HOW CANTIL IS PRESCRIBED

One or two tablets three times a day preferably with meals and one or two tablets at bedtime.

CANTIL—TWO FORMS

CANTIL (plain) — 25 mg. of CANTIL in each scored tablet — bottles of 100.
CANTIL with Phenobarbital — 25 mg. of CANTIL and 16 mg. of phenobarbital (Warning: May be habit forming.) in each scored tablet — bottles of 100.
CANTIL is the *only* brand of N-methyl-3-piperidyl-diphenylglycolate methobromide.

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LAKESIDE

FOR
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NEWS

completely furnished his Atlanta home. What's more, he became interested in needlepoint and upholstered several chairs he'd built.

One houseful of furniture was enough, he finally decided. So he sold his tools and began looking around for other pastimes.

"One day in 1947," he recalls, "I noticed my receptionist knitting a pair of argyle socks. The process looked fascinating. After a few brief lessons, I mastered the technique well enough so that I was able to knit a number of pairs of argyle socks for my friends."

About the same time, during a

visit to Miami, Fla., he was shown another physician's orchid collection. Within a year, Dr. Laws built two greenhouses and stocked them with a few mature orchid plants and several thousand seedlings. "Although I still can't call the hobby profitable," he says, "I do sell blooms and plants. And I've raised a special hybrid orchid that's registered under my wife's name."

Telephone Message Form Speeds Diagnosis

If the doctor's aide got more information from patients who called while her boss was out of the office, she'd save the physician many valuable minutes he must otherwise spend in asking clinical questions later on.

That was the thinking of Dr. Walter L. Portteus of Franklin, Ind., a general practitioner who's secretary of his state's Blue Shield plan. It led him to devise a new kind of telephone message form for the use of his aide. As illustrated at left, the form provides room for a lot more specific information than usual message slips call for.

It's now being used in many more offices than that of Dr. Portteus. Indiana's Blue Shield plan has

TELEPHONE MESSAGE

Date Jan. 8 1957

Name Peter R. Tuckerman

Address 444 Eastview Apt. 32

Complaint Headache, cold

How Long 24 hrs. Temp. 100.5

What Has Been Done Aspirin, bed rest

Cough No Prod. Color

Ears None

Vomiting No Diarrhea Yes

Pain Headache Location None

GU None

Browns None

Bleeding None

How Much None From None How Long None

Visit None

Phone No. GL 3-4343 Time of Call 9:20 AM

Write It Down and Be Sure!

Recommend BLUE SHIELD and Be Safe!



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The gentlest doctors in town

use

Nupercainal®

soothing topical anesthetic

OINTMENT, 1%, in 1-ounce tubes with
"peel-off" labels and rectal applicator;
1-pound jars for office use.

CREAM, 0.5%, in 1 1/4-ounce tubes.

OPHTHALMIC OINTMENT, 0.5%, in oph-
thalmic-tip tubes of 4.0 Gm. each.

- to control topical pain in minor office procedures and in the removal of surgical dressings.
- to control pain and itching in dermatitis, anorectal disorders, mucocutaneous lesions, chronic ulcers, abrasions, sunburn and other minor burns.

Nupercainal® Ointment (dibucaine ointment
CIBA)

Nupercainal® Cream (dibucaine cream CIBA)

Nupercainal® Ophthalmic Ointment (dibucaine
ophthalmic ointment CIBA)

C I B A

SUMMIT, N. J.

NEWS

been distributing the form in quantity to doctors throughout the Hoosier state.

The A.M.A.'s Influence in Congress Is Challenged

"If the A.M.A.'s against it, the bill won't pass." That's what Washington observers used to say when analyzing the chances of various health measures. But recently they've been saying something different.

Listen, for example, to Gerald G. Gross, editor of the weekly Washington Report on the Medical Sciences:

"Twenty-six health bills [were] enacted in 1955-56 . . . The passage of not one single health bill could be attributed to the initiative or militant backing of [the] A.M.A.

"Where [the] A.M.A. mounted an initiative—as in striving diligently for [the] Bricker resolution and [a] tax-deferred pension plan for self-employed professionals—no Congressional action was taken.

"Where [the] A.M.A. took a militant stand in opposition—for example, against Social Security liberalization and military commissioning of doctors of osteopathy—the legislation went through with relatively little difficulty."

How to Explain Witness Fees to the Jury

"Doctor, how much are you getting for testifying in this case?"

That's a question you're likely to

PHENAPHEN® PLUS



NOSE COLD

each coated tablet:

Phenacetin (3 gr.) . . .	194.0 mg.
Acetylsalicylic Acid (2 1/2 gr.) . . .	162.0 mg.
Phenobarbital (1/4 gr.) . . .	16.2 mg.
Hyoscamine Sulfate . . .	0.031 mg.
Prophenpyridamine Maleate . . .	12.5 mg.
Phenylephrine Hydrochloride . . .	10.0 mg.



New CONTROLLED Light!



No. 1785 W/C "Senior"
SUPER POWER LIGHT
(With Caster Base)

Now . . .

- LIGHT INTENSITY ADJUSTABLE FROM 500 TO 5000 FOOT CANDLES
- LIGHT PATTERN ADJUSTABLE FROM 6" DIAMETER and UP
- ADJUSTABLE TO ANY ANGLE OR POSITION

Hospital-type, shadowless illumination for diagnosis, minor surgery, etc. BIG 12 1/2" lifetime reflector gives MORE LIGHT at LESS COST. Heavy base with easy rolling casters. Price only \$99.50 F.O.B. factory.

Ask Your Dealer
for a Demonstration

BURTON MANUFACTURING CO.
2522 Colorado Ave. Santa Monica, Calif.

Now from Bauer & Black

the first 51 gauge elastic stockings

So like regular nylons that your patients with varicose veins will never again feel "different" (and they'll have proper support, too)



Here at last are elastic stockings your patients will take to cheerfully. 51 gauge, made with threads twice as thin and twice as light as former kinds. So sheer they make "overhose" a thing of the past. Full-fashioned like regular nylons.

Yet, sheer as they are, Bauer & Black's 51 Gauge Elastic Stockings provide proper remedial support. Pressure decreases gradually from the ankle up, gently speeding venous flow.

New full-footed style

These full-footed stockings can be worn all day, every place your patient may go. Heel and toe are non-elastic, made

with Helanca® stretch nylon to prevent cramping or binding.

To be sure of patient cooperation, doctor, aren't these the elastic stockings to prescribe?

Of course, you and your patients can still choose from the complete Bauer & Black line: nylon or cotton . . . open toe or closed toe . . . knee length, above knee or extra long . . . variety of prices.

51 Gauge Elastic Stockings

BAUER & BLACK

Division of The Kendall Company
309 W. Jackson Blvd., Chicago 6, Ill.

NEWS

hear when you appear as an expert witness. According to Donald B. Doud, writing in the Journal of Forensic Sciences, the opposing lawyer may thus try to "establish a doubt as to [your] reliability by implying that [you're] for sale to the highest bidder."

What's the best way to cope with the question?

Doud recommends three possible answers, depending on the circumstances:

1. If you haven't settled the fee beforehand: "I expect to render a fair and reasonable bill at the conclusion of this case. I have not totaled up my time . . . nor do I know how long I will be in court."

2. If you've agreed on an hourly or per diem rate: "My fees are based on the usual professional rate of \$20 per hour, of which [almost] half will go to my overhead expenses."

3. If you've been paid on account: "I have been paid \$100 for the many hours spent in investigating this problem, and naturally I [will not render] a bill for testimony until my work is finished."

Another possible solution, the writer suggests, is to beat the cross-examiner to the punch. During direct examination, you can "frankly discuss the basis for [your] fees, such as the amount apportioned to travel expense and to materials . . .

announcing —————→
the first **analgesic-hypnotic**
new **Sominat**

dichloralantipyrene National

a new molecular complex of chloral hydrate with antipyrine
for built-in pain relief

...for safer, sounder sleep
without side effects or addiction

This type of frankness hurts the 'below-the-belt' type of attorney who loves to imply that he is digging something unpleasant out of the witness."

Remember above all, adds Doud, that you're entitled to adequate compensation and needn't feel guilty about getting it: "It is poor practice for any professional man to undercharge . . . because of a fear that he will offend.

"To the ordinary lay juror," the writer explains, "an expert fee of \$150 may seem outrageous and exorbitant." At the same time, an overmodest charge "may be attributed to inexperience, lack of reputation, or second-rate work." He

concludes that "a fair charge for court work would be \$150 to \$300 per day."

Doctor-Owned Pharmacies Still Stir Druggists

One clause in the A.M.A.'s proposed new ethics code has the nation's pharmacists keeping their fingers crossed. They're hoping, says American Druggist magazine, "that adoption of this particular rule [will] reverse the trend toward doctor ownership of pharmacies."

The clause in question says: "In the practice of medicine, a physician should limit the source of his professional income to medical



continuous sleep **Sominat** is a new molecular complex of chloral hydrate and antipyrine, giving a unique synergistic effect which increases hypnotic action (over ordinary chloral hydrate) by 35%. Sominat assures **continuous sleep** of a more revitalizing kind than that provided by other hypnotics.

comfort from pain **Sominat** exerts an analgesic effect offered by no previous hypnotic. The action of antipyrine in this complex relieves and protects the patient from the aches and pains which so often prevent sleep.

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1. Rice, W. B., and McColl, J. D.: *J. Am. Pharm. A.* 45:137 (Mar.) 1956.

Each tablet contains the equivalent of

Chloral hydrate 382 mg.

Warning: May be habit forming.

Antipyrine 218 mg.

Usage and Administration: As HYPNOTIC: 1 to 2 tablets with full glass of water. As ANALGESTIC: 1/2 tablet. Supplied: Tablets, 600 mg. Scored. Bottles of 100.

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NEWS

services actually rendered by him to his patient." (This clause in the proposed A.M.A. code contrasts with a clause in the present code that says: "It is not unethical for a physician to . . . supply drugs, remedies, or appliances as long as there is no exploitation of the patient.")

According to American Druggist, the trend toward physician-owned pharmacies has recently accelerated. A survey by the magazine turned up more than 520 such pharmacies in medical clinics. It also revealed that the number has been going up 10 per cent annually for the last several years. Texas is reported to have 134 such pharmacies; California, 78; Illinois, 45.

Doctors Set Up Laymen's Advisory Committee

The physicians of one state have decided to act on the principle that "we can profit most by seeing ourselves as others see us."

To get an idea of how private medicine can best serve the community, the Oregon State Medical Society's public relations committee has established what it calls "a citizen sounding board." Its members include several editors and publishers, several industrial and labor leaders, an advertising man, a radio executive, and a farmer who's also a member of the state legislature.

Purpose of the board, as the doctors explain it, is "to explore new

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areas where private medicine can be of better service to the people of Oregon . . . There are no strings attached."

Joint meetings of the doctors and their new advisory group have already proved fruitful. One new idea, to go into effect shortly: An award to be presented annually to the doctor who has done the most for his community "in affairs not related to the practice of medicine."

'V.A. Hospitals a Boon,' Claims Local Observer

When a large V.A. hospital is built in your community, are you and your colleagues bound to suffer? Not at all, says Harry B. Davidson, attorney and clinic manager of Maywood, Ill.

"Ten years after one such invasion in this locale," he claims, "most of the area's doctors agree that V.A. hospitals are a boon to private medical practice."

Here's the story, as he tells it:

"In 1946, our community became host to the Edward Hines Jr. Hospital—the largest V.A. facility in the Chicago area. It has 3,000 beds and 136 buildings. It employs sixty-one full-time physicians (most of them specialists), 113 residents, and a number of Chicago consultants. Against this our township has approximately sixty private doctors and an eighty-five-bed hospital. Many local medical people expected to be swamped. . . . [MORE]

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Lemere, F.: Northwest Med. 54: 1098, 1955.

2 "... the patient [taking Miltown] never describes himself as feeling detached or 'insulated' by the drug. He remains... in control of his faculties, both mental and physical, and his responsiveness to other persons is characteristically improved."

Sokoloff, O.J.: A.M.A. Arch. Dermat. 74: 383, 1956.

3 "Of special importance is the fact that Miltown does not appear to affect autonomic balance—which in alcoholics is often unstable . . ."

Thimann, J. and Gauthier, J.W.: Quart. J. Stud. Alcohol. 17: 19, 1956.

4 "The [relative] absence of toxicity, both subjectively and objectively, is an important feature in favor of Miltown. In addition, there were no withdrawal phenomena noted on cessation of therapy, whether it was withdrawn rapidly or slowly."

Borrus, J.C.: J.A.M.A. 157: 1594, 1955.

5 "Miltown is of most value in the so-called anxiety neurosis syndrome, especially when the primary symptom is tension . . . Miltown is an effective dormifacient and appears to have . . . advantages over the conventional sedatives except in psychotic patients. It relaxes the patient for natural sleep rather than forcing sleep."

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AN IMPORTANT CLINICAL CONSIDERATION: *the rising incidence of moniliasis since the introduction of broad spectrum antibiotics*

EXAMPLE: *Candida albicans (monilia) as a cause of vaginitis*^{1,2}



The use of *any* antibiotic may cause the troublesome and potentially serious complication of monilial superinfection by suppressing the bacterial flora of the intestinal tract and allowing monilia to proliferate.

"Even one day of therapy may be sufficient to provoke an unfavorable chain of events and this fact should be kept in mind whenever a patient is to receive an oral antibiotic for even a minimal period of time."³

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References:

1. Lee, A. F., and Keller, W. S.: *Newer Med.* 53:1227, 1954.
2. Pace, H. R., and Schantz, S. I.: *J.A.M.A.* 162:268, 1956.
3. Mitzner, W. I., et al.: Paper presented at 4th Annual Symposium on Antibiotics, Washington, D. C., Oct. 27, 1956.

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NEWS

"But contrary to what we feared, the new institution did *not* take a large segment of the otherwise paying public away from private medicine. Many of the beds in the Edward Hines Jr. Hospital have always been occupied by paraplegic, TB, or long-term orthopedic patients, who'd normally be in institutions.

"Half the patients at all times are psychotics or neuropsychotics, who usually can't afford to pay private physicians anyway. Of the rest, most are admitted on the recommendation of a private doctor. And to get in they *must* be unable to pay on a private basis."

Davidson also claims that "not only does the hospital not take away patients from local doctors; it actually contributes to the habit of going to one's own doctor. A veteran who's been successfully treated at the V.A. hospital usually has friends and relatives not eligible for V.A. benefits. And they're often led by his example to seek medical relief. . . ."

How Hungary's Refugee Doctors Are Faring

Many Hungarian doctors have already found jobs on American hospital house staffs. More of the refugees are being placed every day. But Camp Kilmer, N.J., still "has a backlog of unplaced physicians, with more arriving daily," reports Dr. Howard A. Rusk, consultant to the United Nations. [MORE ▶]



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MEDICAL ECONOMICS • FEBRUARY 1957 349

NEWS

Even before the Hungarian influx, over one-fourth of American house-staff positions were filled by noncitizens. During the next year or so, these internes and residents will be joined by many Hungarian refugees, seeking to support themselves and their families until they can get licenses.

Dr. M. Arthur Kline of the American Medical Society in Vienna reports that he's counted more than 300 refugee physicians so far. "Practically every doctor in Vienna has opened his home to a Hungarian colleague and his family," Dr. Kline says.

American doctors have been helping out, too. The A.M.A. has

already cabled \$5,000 to Vienna for relief of Hungarian physicians. More recently, the New York State medical society sent \$5,000. Individual doctors are contributing via Dr. M. Arthur Kline, the American Medical Society, 11 Universitätsstrasse, Vienna 1, Austria.

Ophthalmologists Plan Publicity Campaign

Less than a year ago, the nation's internists laid the foundations for a new medical society. Its major aim: to increase understanding of internal medicine among both doctors and laymen. Now the ophthalmologists are following suit. They

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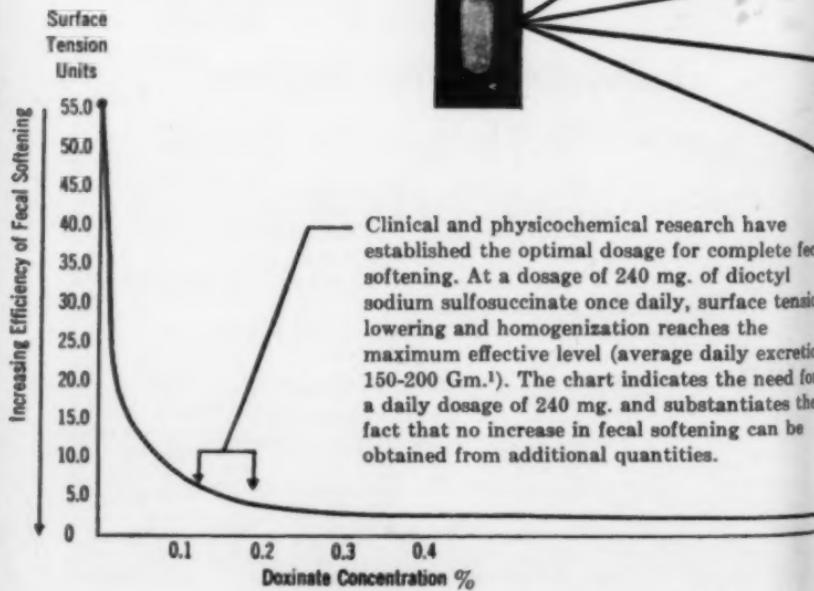
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have set up a new research and educational organization known as the National Medical Foundation for Eye Care. President of the new foundation is Dr. Ralph O. Rychener of Memphis, Tenn.

He notes "an urgent need for an organization [that can] interpret the basic professional and scientific standards of good eye care . . . both to our fellow physicians and to the people whom we serve."

Why is the need for such publicity urgent? Because, say many eye men, certain optometrists are fostering a good deal of public confusion over differences among types of eye care. It's also charged some optometrists attempt medical jobs

they're not trained for, while trying to limit the ophthalmologists to surgical procedures.

M.D.s Threaten Boycott Against V. A. Hospital

Doctors in Oklahoma City, Okla., have given the local V.A. hospital ninety days to stop admitting veterans who have both nonservice-connected illnesses and adequate insurance coverage. After February 28, according to the county medical society's resolution, "member physicians who continue to participate in this program of veteran care. . . will. . . be considered as practicing unethical medicine"—

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Calcium, elemental	150 mg. (as calcium carbonate 375 mg.)
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1. Blanchard, K., and Ford, R. A. *Journal Lancet* 74:443, 1954
2. Blanchard, K., and Ford, R. A. *Rocky Mt. M. J.* 52:278, 1955. Caso, L. J., and Frederik, W. S. *Am. Pract. & Dig. Treat.* 2:844, 1954.

In each 5 cc. —

Robitussin®	Glycerol guanacolate	100 mg
	Desoxyephedrine HCl	1 mg
Robitussin A-C®	Glycerol guanacolate	100 mg
	Desoxyephedrine HCl	1 mg
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Robitussin with Antihistamine and Codeine

unless the Will Rogers Veterans Hospital changes its way.

The thing that most needs changing, the Oklahomans hold, is the hospital's habit of collecting fees for medical, surgical, and hospital services rendered to patients covered by workmen's compensation or private health insurance. Dr. Elmer Ridgeway Jr., president of the county, cites this example:

"A veteran with a workmen's compensation injury was hospitalized for six days. He had a Colles fracture of the wrist and an open fracture of the femur. The Colles fracture was reduced by manipulation; a Kirschner wire was inserted into the femur. For this surgery—done by the resident doctor under the supervision of the visiting staff doctor—the V.A. hospital billed the insurance company for \$300. The visiting staff doctor was then paid \$25."

The medical society objects on three counts. First, it says, this is a "plain violation of the Veterans Act." V.A. hospitals are supposed to admit only those non-service-connected cases who can't pay their own way. Yet if a man has adequate health insurance, he's clearly not indigent in the medical sense of the word.

Secondly, the society contends, any V.A. hospital that collects fees intended for physicians is engaging in the corporate practice of medicine.

Thirdly, the V.A. hospital thus puts itself "in direct competition to private hospitals and medical personnel of this community."

The doctors' stand has drawn sharp criticism from veterans' spokesmen. Representative Olin E. Teague (D., Tex.) has denounced the society's ultimatum as "premature and ill advised." And the local American Legion post has branded the proposed boycott as "unpatriotic, callous, and brutal."

But with the deadline rapidly approaching, the medical society is standing firm. It finds support in the position taken by the A.M.A. at its recent Seattle session. There the association condemned as unlawful the V.A. practice of treating veterans who had health insurance and then billing for the cost of their care.

Non-Participation Up For Doctors' Vote

Should doctors use the threat of non-participation as a weapon against government-controlled medical plans? The question was much in the news a few years ago when the immediate prospect of compulsory health insurance rocked the profession. Now the question is again being debated by the Association of American Physicians and Surgeons.

When the A.A.P.S. was organized some fourteen years ago, it in-

NEWS

cluded in its by-laws the following provision:

"When it shall be found by majority vote of the membership . . . that any plan for the provision of medical care . . . is inimical to the public interest or that of the patient and harmful to the profession or the practice of medicine, it shall become mandatory upon every member to refuse participation in such plan."

Some A.A.P.S. members have recently indicated a desire to invoke this provision in order to fight Medicare and the new Social Security disability law.

But other association members not only don't want to invoke it; they want to remove the provision from the association's by-laws.

To help clarify the issues at stake, A.A.P.S President Charles W. Pavey offers the following explanation:

"The A.A.P.S. plan of non-participation is not a proposed 'strike.' A 'strike' means a withdrawal of services. No member of A.A.P.S. proposed or even contemplated a withdrawal of his services from his patients. [In the event of government-controlled medicine, members planned] to continue to serve their rightful employers, their patients, but [to] refuse to become hirelings of the Government. . .

"Some members have questioned whether or not non-participation could be made effective . . . [It] would require unanimity of action by at least more than half of the

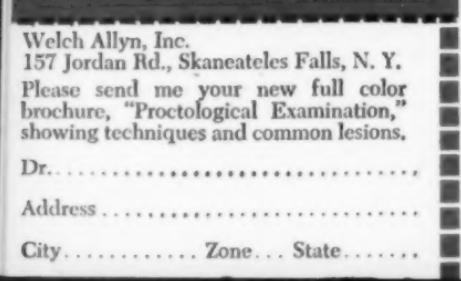
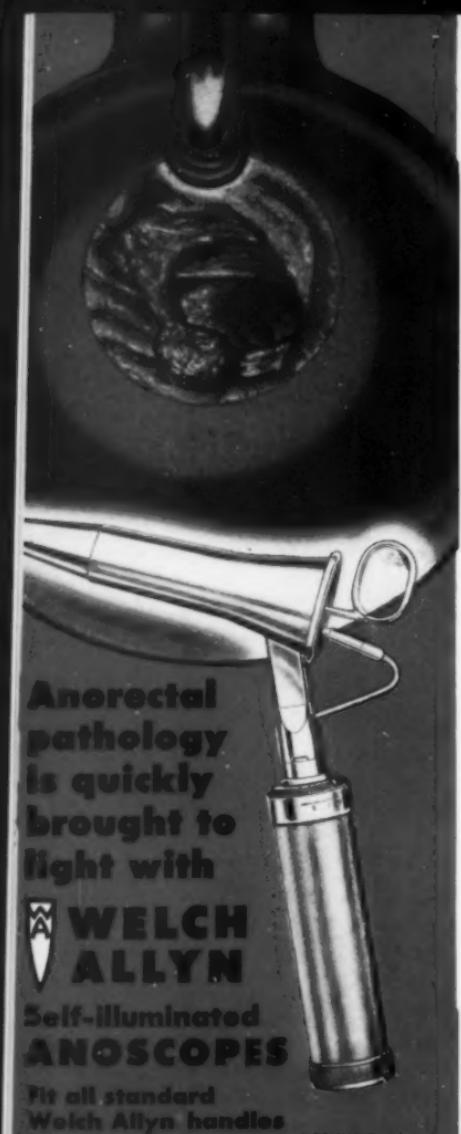
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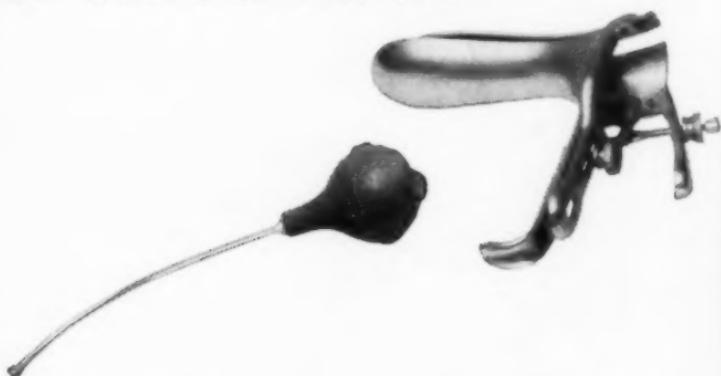
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“cell examination for uterine cancer”



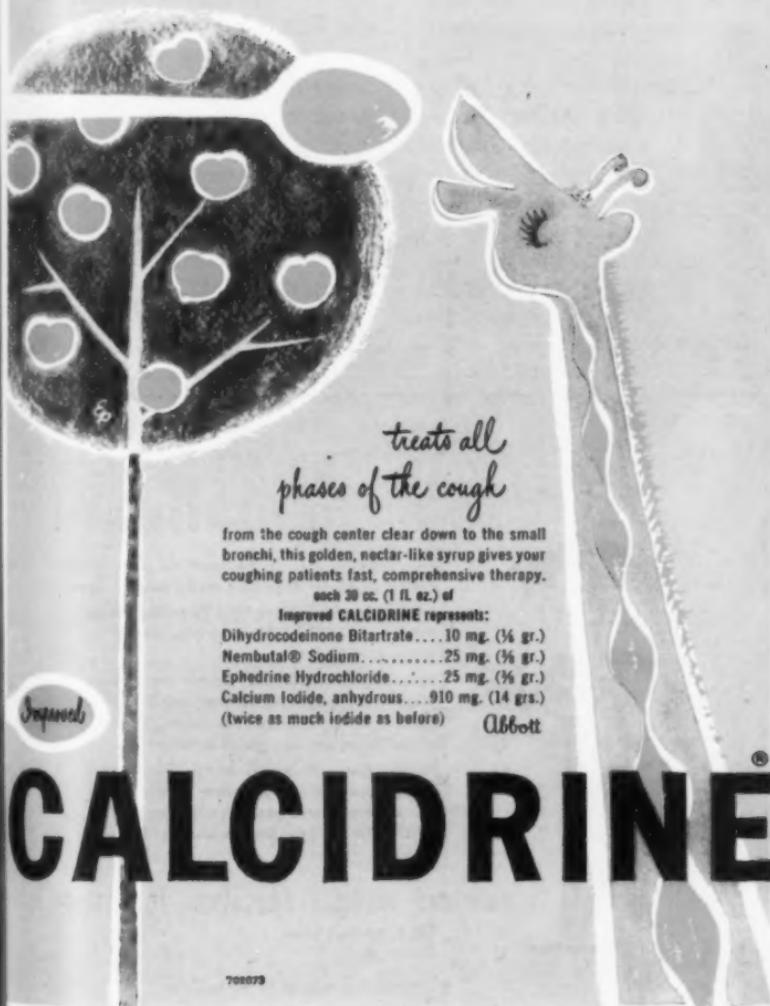
The exfoliative cytological examination is called by some doctors the *cytologic cervical test* and by others the “Pap smear test”. However women find the word “smear” unpleasant and disturbing. Public relations advisors say that broadcasters and editors will dislike the word.

We have therefore adopted “cell examination for uterine cancer” as the term which simply and accurately describes the keystone of this life-saving program. Upon approval by county medical societies and where adequate facilities are available, our local Units will urge women to go to their physicians annually for a *cell examination for uterine cancer*.



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NEWS

practicing ethical physicians . . . Until A.A.P.S. represents a majority of ethical physicians, it could not invoke non-participation with the security of having the act be effective. The association could only exert moral influence by 'recommending' non-participation . . ."

Is it therefore meaningless to retain the by-law?

Or does the idea of non-participation "promise a last-resort fortress where physicians and their patients may seek safety from the clammy and grasping hands of government regimentation?"

Dr. Pavey doesn't answer these questions. He merely poses them for A.A.P.S. members to vote on.

The matter will probably be decided at their annual meeting this coming April.

M.D. Wins National Fame As Beagle Breeder

Do you like the wind on your face, a dog at your side, and a rabbit to hunt? Internist Francis R. Whitehouse of Lynchburg, Va., does. And he has parlayed these pleasures into a potentially money-making hobby.

Until 1951 Dr. Whitehouse got most of his outdoor fun by shooting in the low 80s on Lynchburg golf courses. Then, one day, he bought a pair of beagles for his



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Every practicing physician has heard the appeal of the medical schools for desperately needed financial support. The American Medical Education Foundation has an annual quota of \$2,000,000 to be subscribed by practicing physicians.

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But time flies — the need is immediate — so this is another appeal for your immediate contribution either through your Alumni Committee Secretary or direct to the American Medical Education Foundation.

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NEWS

children. He has since raised twenty times that number, gained national prominence as a beagle breeder, and come within a hair's breadth of coping the top trophy in the National Beagle Club's annual field trials.

"I got my first beagles as pets, of course," says the doctor. "But pretty soon I found myself hunting with them whenever I could steal the time." Before long he decided to test his dogs against others in some local field trials.

Much to his disappointment, they fared none too well. "This stirred me," he recollects, "to breed and train beagles that could win."

Over the next few years, Dr. Whitehouse raised close to forty dogs, built a kennel, and hired a man to take care of it. Soon he was spending most of his spare hours with the dogs.

All this care and training eventually paid off. A year ago last November, one of the doctor's dogs took a first prize in the National Beagle Club's field trials. The doctor received a published accolade from Sports Illustrated magazine.

In 1956 the Lynchburg internist did even better: So many of his dogs placed high in the various trials that they finished a close second for the national club's major trophy, awarded for all-around performance.

Despite the time required by his hobby, 42-year-old Dr. Whitehouse also heads a corporation en-

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Action:

Two-way spasmolysis . . . Spasm is relieved and gastric hypermotility is checked by the muscletropic and neurotropic effects of *Bentyl*[®]—more effective than atropine, without the usual side effects.¹

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Bentyl (dicyclomine)
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Gel 400 mg.
Magnesium Oxide 200 mg.
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Methylcellulose 100 mg.

Dosage:

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Tablets—bottles of 100 and 1,000.

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gaged in a cooperative building program to erect offices for twenty-six Lynchburg doctors. And he's trying to make a business of his beagles, too. "Right now, the venture gives me a definite tax advantage," he says. "Eventually, I expect it to pay its own way."

Competition for Aides Is Increasing

Hospitals are becoming more desirable places for nurses, technicians, and medical secretaries to work. And that means stiffer employment competition for the doctor who has such helpers in his own office.

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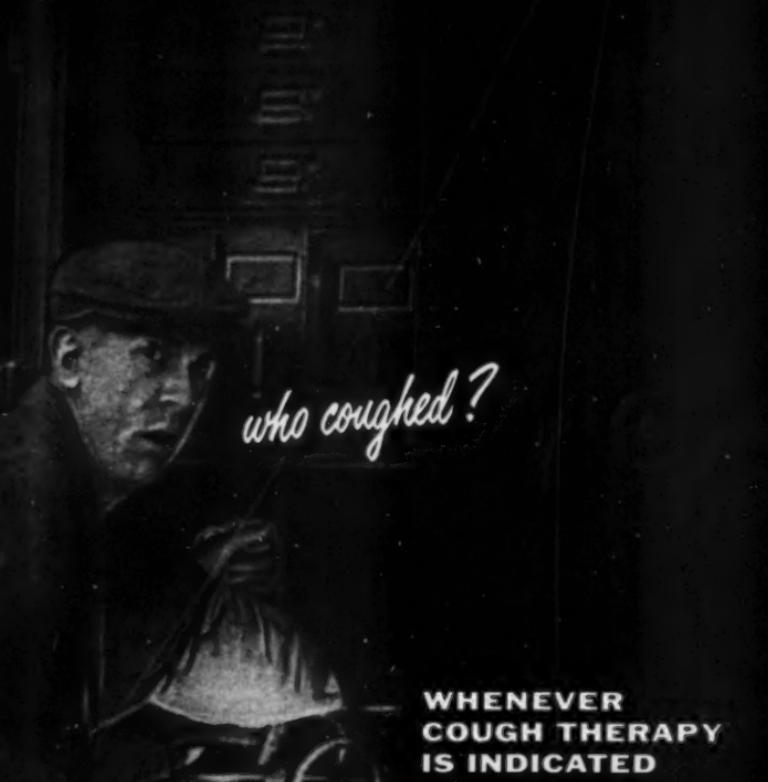
¶ Their wages are going up. Just three years ago, starting salaries for general-duty nurses ranged from \$150 to \$240 a month. Now the latter figure is the most common starting salary. Payments to technicians and medical secretaries have risen correspondingly.

¶ Their work week is getting shorter. In 1950, the 40-hour week prevailed in only seven Philadelphia hospitals. Today it's standard in fifty-seven hospitals.

¶ Their fringe benefits are getting better. Pensions and retirement plans are quite common in Philadelphia hospitals.

But fewer perquisites are being offered. In 1954, twenty-four local hospitals gave no maintenance to their help; today thirty-three hospitals are in this category.

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NEW REPORT reveals that

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by supplementing the diet with

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"In all 25 cases there was significant symptomatic improvement within a week or two of starting the Entozyme and the high protein diet . . ."

Of 14 patients who were taking insulin . . . 4 patients were able to discontinue insulin completely, while the other 10 all experienced a decrease in their insulin requirements."

A highly significant clinical report (abstracted on the facing page) reveals that, with Entozyme added to a special high protein diet in diabetes mellitus, insulin could be discontinued entirely in 29%, cut by four-fifths to one-half in 50%, and by one-half to one-third in 21% of cases receiving insulin. Marked symptomatic improvement occurred in all cases.

Entozyme was employed to insure proper digestion, to restore the nitrogen balance, and to make available the full lipotropic activity of protein.

Entozyme is a natural replacement of digestive secretions. Each tablet is formulated so that pepsin is released in the stomach, and pancreatin and bile salts in the upper intestine. In addition to its value in diabetes mellitus, it has proved most useful in the management of chronic nutritional disturbances, dyspepsia, psoriasis and various degenerative diseases associated with aberrations in protein metabolism.

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Robins

XUM

THE VALUE OF ENTOZYME® IN THE CLINICAL MANAGEMENT OF DIABETES MELLITUS

PRELIMINARY REPORT*

Clinically it was noted that some diabetics—particularly those who seemed to need protein the most—failed to derive the anticipated benefits from a high protein diet. It appeared likely that the lack of improvement could be ascribed to a partial failure of their digestive function. For this reason, it was decided to add pancreatic digestive enzyme tablets to the high protein diet to make sure that all food taken was properly digested.

The 25 patients used in the study were drawn from the author's own private practice and from the diabetic clinic of the Dade County Hospital at Kendall, Fla. While 11 were controlled by diet alone, 14 were taking insulin.

Diets used were based on the standard ADA diets fortified by the addition of approximately 20 Gm. of protein (15 Gm. of gelatin and 10 Gm. of brewer's yeast) divided into 5 or 6 feedings. Two Entozyme® tablets were prescribed 3 times a day with meals, and one Allbee® capsule daily to supply fully adequate B-complex vitamins.

Results—All 25 cases showed significant symptomatic improvement within a week or two of starting the Entozyme and high protein diet. In 16 of the 25, there was a significant decrease in the serum cholesterol; and in the 14 patients taking insulin, there was a decrease in the insulin requirement.

In most cases, the postprandial blood sugar began to rise within a week or two after starting therapy—a result that had been anticipated because of improved digestion. The insulin dose was not increased, however, as there was no accom-

panying acidosis or acetonuria. Eventually, the postprandial blood sugar declined toward normal in all cases.

When the blood sugar had fallen to the pre-experimental level, the insulin dose was decreased by 2 units or more. Subsequently, the postprandial blood sugar again rose briefly, but once again dropped toward normal. When it reached the pre-experimental level, the insulin dose was once more decreased. In this fashion, 4 patients were able to discontinue insulin completely, while the other 10 all experienced a material decrease in requirements.

Discussion—The "well-regulated" diabetic may still fall prey to the degenerative complications of the disease, since it is not enough merely to guard against ketosis or hypoglycemic reactions. In order to preserve protein balance, it is necessary also to guard against a drop in blood sugar so low as to stimulate hepatic glycogenesis, lest the alimentary canal be unable to absorb enough nitrogen to maintain protein balance. Therapy calls for a high protein diet amply fortified by vitamins and (at least in the beginning) by the digestive enzymes of the pancreas, in order to stimulate protein recovery and to enable the lipotropic action of the protein to become fully manifest.

Conclusions and Summary—A group of 25 diabetics treated with a special high protein diet, oral pancreatic enzymes (Entozyme), and careful regulation of their insulin dosage so that neither excessive hyperglycemia nor hypoglycemia occurred showed significant symptomatic improvement. In most cases there was not only a decline in the serum cholesterol levels, but also a reduction in insulin requirements.

It is suggested that this improvement is due to redressing the nitrogen balance and making available the lipotropic activity of protein, as well as other intrinsic factors essential to normal tissue metabolism.

*Lowenstein, B. E.: The Value of Entozyme® in the Clinical Management of Diabetes Mellitus: Preliminary Report. American Pract., September, 1956.

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FROM THE PUBLISHER

Who's Average?

The average reader of MEDICAL ECONOMICS, in case you've ever wondered, is a 42-year-old physician who practices in a city of 100,000. He has a wife and three children, whom he supports on a net income of \$18,122 before taxes. To earn this sum, he takes care of twenty-four patients a day.

For ready reference, we call this average reader "the doctor from Peoria." All in all, we know quite a bit about him. We even know what he looks like: He's 5' 10", weighs 170, and wears glasses.

There's one other fact about this man that we constantly have to remind ourselves of: *He doesn't exist.* There is no "average reader" of this magazine or any other.

Consider some of the diverse types who look to MEDICAL ECONOMICS for help: men of 25 and men three times that age; doctors in isolated hamlets and doctors in metropolises; M.D.s active in mining medicine, hotel practice, and

hospital staff work. What's "average" about these physicians?

True, they all have certain *basic* problems—e.g., insurance, investments, and income taxes. But each type also has *special* problems. Young men want help in building up their practices; older doctors want ideas for retirement planning. City doctors want solutions for hospital staff problems; country doctors want ways to ease their collection difficulties.

That's why a number of MEDICAL ECONOMICS articles are beamed at specific groups of readers—not at that hypothetical average, "the doctor from Peoria." Whenever a substantial minority seems interested in any given problem, we'll take it up in print.

Something troubling you? Then just let us know what it is. Remember that MEDICAL ECONOMICS serves as a clearinghouse of useful, interesting ideas—and a clearinghouse can be effective only when those who take from it also give to it.

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